Rockley Dene Homes Limited

Cherry Hinton Nursing Home

Inspection report

369 Cherry Hinton Road
Cambridge
Cambridgeshire
CB1 8DB

Tel: 01223210070
Website: www.tlc-group.net

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Cherry Hinton Nursing Home is registered to provide accommodation, nursing, and personal care, for up to 59 people. At the time of our inspection there were 57 older adults and adults living with dementia living at the home. There are a number of communal areas, including a hairdressing salon, lounges and dining areas, a conservatory and a garden for people and their visitors to use. The home is situated over three floors, with the ground floor and first floor providing accommodation. There are accessible bedrooms on both floors by either the stairs or a lift. There were communal toileting and wash facilities for people who used the service.

A previous inspection took place on 2 February 2015 and the service was rated overall as 'good'. There were no breaches of the Health and Social Act 2008 (regulated Activities) Regulations 2014. However, we found that the provider 'required improvement' under the question. Is the service effective? During this inspection we found that the provider had made some of the improvements required.

This unannounced inspection took place on 19 August 2016.

There was no registered manager in place during this inspection. A new manager was working in the home and they were currently applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Applications were still in the process of being made to the local authorising agencies to lawfully restrict people's liberty where appropriate. Staff were able to demonstrate a basic understanding of the MCA and DoLS to reduce the risk that people would not have their freedom restricted in an unlawful manner.

Plans were in place to minimise people's identified risks and to assist people to live as independent and safe a life as possible. We found that records were in place for staff to monitor people's assessed risks. However, we noted that that records were not always completed accurately by staff.

Most people were supported by staff in a respectful and kind way. We saw that there were lots of positive interactions between staff and people. However, there were missed opportunities for staff to fully engage with the people they were assisting and not all staff were caring to the people they were supporting.

Arrangements were in place to support people with their prescribed medicines. However, we could not be confident that people received their medicines as prescribed. Information on why a person's medicine could be administered covertly was not always recorded and 'as required medicines' did not have robust protocols in place as guidance for staff. People's medicines were stored and disposed of appropriately.

When required, people were referred to and assisted to access a range of external healthcare professionals. People were supported to maintain their health and well-being.

People's support and care plans gave prompts and guidance to staff on any individual assistance a person may require. They included the person's wishes on how they were to be supported and their likes and dislikes. An activities co-ordinator and staff assisted people with their interests and activities and promoted social inclusion. People's family and friends were encouraged to visit the home and staff made them welcome.

Staff were trained to provide care and support which met people's individual needs. The standard of staff members' work performance was reviewed during supervisions, competency checks and appraisals. This was to make sure that staff were deemed competent and confident by the manager to deliver people's support and care needs.

Staff understood their responsibility to report any suspicions of harm.

There were pre-employment safety checks in place to ensure that all new staff were deemed suitable to work with the people they supported. There was a sufficient number of staff to provide people with safe support and care.

The manager sought feedback from people and their relatives. People who used the service and their relatives were able to raise any concerns or suggestions that they had with the manager and staff.

Staff meetings took place and staff were encouraged to raise any ideas or concerns that they may have had. Quality monitoring processes to identify areas of improvement required within the home were in place and formally documented any action required.

Information received after our visit showed that the management team were not always aware of the day to day staff culture.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could not be assured that they would be assisted with their medicines as prescribed. Medicines were stored and disposed of safely.

Staff were aware of their responsibility to report any suspicions of poor care practice or harm. People's care and support needs were met by a sufficient number of staff.

Although records were in place for staff to monitor people's assessed risks, these were not always accurate which meant that people were placed at risk. Safety checks were in place to ensure that new staff were deemed suitable to look after the people they assisted.

Is the service effective?

Good

The service was effective.

Staff were aware of the basic key requirements of the MCA and DoLS to make sure that people were not having their freedom restricted in an unlawful manner.

Staff were trained to meet people's needs.

Supervisions, competency checks and appraisals of staff were carried out to ensure that staff provided effective support and care to people.

People's health needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff were caring and patient to the people they supported.

Staff respected people's dignity and privacy.

People were assisted by staff to maintain their independence. Staff encouraged people to make their own choices about things that were important to them.

Is the service responsive?

Good

The service was responsive.

Staff encouraged people to take part in activities and supported people to maintain their links with the local community.

There was a system in place to receive and manage people's compliments or complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place. The management team were not always aware of the day to day staff culture.

There was an effective quality assurance system in place to ensure that when needed improvements were actioned or on-going. Not all audits found all areas of improvement required.

People and their relatives were able to feedback on the quality of the service provided.

Cherry Hinton Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 August 2016, and was unannounced. The inspection was completed by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of working with or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete and return a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. The provider completed and returned the PIR form to us and we used this information as part of our inspection planning.

We also looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law. We received feedback about the quality of the service provided from a representative of Cambridge County Council contracts team and the Cambridge and Peterborough Clinical Commissioning Group. We used this information as part of our inspection planning.

We spoke with 12 people who lived in the service, and five relatives of people who used the service. We also spoke with the home manager, deputy manager, two nurses, and, two care workers. We spoke with the maintenance manager, two activities coordinators and a hair dresser. Throughout this inspection we observed how the staff interacted with people who lived in the service who had limited communication skills.

We looked at five people's care records, the systems for monitoring staff training and two staff recruitment files. We looked at other documentation such as quality monitoring, service users and relatives' surveys, and accidents and incidents. We saw records of compliments and complaints, the business contingency plan and medication administration records.

Requires Improvement

Is the service safe?

Our findings

We could not be confident people received their medicines as prescribed. The provider's policy in recording the administration of people's medicines had not always been followed by staff. We saw that there were gaps in people's medication administration records (MAR). This meant that staff had not always recorded whether a person's medicine had been given or not given. Including any action taken by staff if a person refused their medication. We raised this with the manager who said, "The medication policy will be discussed [with staff], followed and audited." They stated that would be actioned as soon as possible through staff handover's, staff meetings, and where necessary, with individual nurses.

There were not robust protocols in place for medicines that could be administered 'as required.' This meant that staff did not have the necessary information and guidance to know when the medicine should be administered or at what dose. For example, information in one person's protocol showed they should have a half to one milligram of [named medicine] to be taken for, "anxiety, distress and aggression." However, the nurse was not able to tell us the specific process in place when the person required either a half or one milligram of the medicine.

One person's records showed that they had been administered a medicine that was prescribed on an 'as required' basis. The manager was unable to find any report or document that showed us why the person had been given the medicine. The manager agreed that the information in the protocols we showed them were not detailed enough for staff and they would ensure all protocols would be updated as soon as possible. They also told us that appropriate and robust paperwork would be put in place to record the reason why a person exhibiting increased anxiety had been given a medicine to help reduce their anxiety.

On one floor of the home, we found that there were six people who were given covert medication [medicine disguised in food or drink]. We noted that this had been agreed by the GP, however, the reason why the medicine was to be given this way, was not always formally recorded.

Medication audits had been completed monthly. Where issues had been noted a second audit had been completed to ensure the action required had been taken. However, there were issues that we found during our inspection, such as 'as required' medicines that had not been noted as an area that required improvement during the audit.

This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Arrangements were in place to ensure medicines were stored safely and securely and medicine trolleys were locked. One nurse told us that there were two medicine trolleys on the ground floor and so each person could be administered their medicines in a timely way and in their room if they preferred. We reviewed the arrangements for managing medicines and MAR charts. Staff told us that only the nurses administered medication to people in the home. Nurses said they had been regularly trained and had their competence to administer medicines assessed. One nurse said, "I have had my competency checked by other nurses and

we [nurses] do it for new staff [nurses]." We noted that where one or two tablets (such as painkillers) could be administered, in most cases the number of tablets had been recorded.

Care staff applied any creams for people. There was information in people's bedrooms that showed the cream name and a body map to show where the cream should be applied on the person's body as guidance for staff.

Ten out of 12 people who used the service and their relatives told us that they or their family member felt safe in the home. One person said, "I do feel safe, the staff are always around." Another person told us, "Generally yes I do feel safe." A third person said, "I do feel safe here, yes…no problems with feeling safe." However, a fourth person told us, "No, I don't really feel safe – I don't know what's going on and this is a very noisy room….it is not very restful."

Staff told us that they had undertaken safeguarding training and records we looked at confirmed this. They demonstrated to us their knowledge on how to identify the different types of harm and report any suspicions of harm or poor care practice. Staff told us what actions they would take in protecting the people they assisted and reporting such incidents. One staff member said, "I would inform the nurse in charge. I would record everything on the [computer] system and I would write down everything that I had told the nurse." Staff were aware that they could also report concerns to external agencies such as the Care Quality Commission (CQC), GP's and, social services. There was a poster on a communal notice board which gave details of organisations to contact to 'whistle-blow' if people, their visitors and staff had any concerns.

People had individual care plans and risk assessments undertaken for any identified risk, support and health care needs. We saw that people were kept as safe as possible and risk assessments were completed. For example, there was one person who could not undertake certain activities because of their personal health issues. The information of the risk was detailed in their file. This meant that staff ensured the type of activities that would cause them to be at risk were not suggested to the person.

Another person was being monitored for their food intake. Information on how to support this person had been provided by the dietician and the person was provided with a fortified diet. We saw fluid charts had been completed and the expected range of fluid input recorded on the chart. However, we noted that in one case the levels drunk by the person were well below the lowest level they should have drunk. When we spoke with the nurse they told us that the person was being monitored. The manager said that they were aware of the person and that the GP was aware of the situation. They said that they would be discussing the fluid levels for the person with their GP to ensure their health and wellbeing. Information of concern received after this inspection showed that some monitoring documents were not always an accurate record.

We saw that the provider had a business contingency plan for the home in the event of a foreseeable emergency as a prompt for staff. This showed us that there were plans in place to support people to be evacuated safely in the event of such an emergency, for example a fire.

Records showed and staff confirmed to us that that pre-employment safety checks were carried out prior to them starting work at the home and providing care. One staff member said, "[My] references and safety checks were in place before starting [work]." Checks included references from previous employment, a criminal record check that had been undertaken with the Disclosure and Barring Service, proof of current address, photographic identification. Any gaps in employment history had been explained. These checks were carried out to make sure that staff were deemed suitable to work with people living in the home.

Our observations showed that during this inspection there were sufficient staff on duty to meet people's

assessed needs. We saw staff in communal areas of the home supporting people and on the corridors, available to ask for information when needed. Staff were busy, but they did not rush people, and supported people at their own preferred pace. We saw that people had their dependency levels assessed to ascertain whether they needed support from either one or two staff members. The manager talked us through how this information determined the staffing levels that met people's care and support needs. This indicated to us that there was a process in place to determine the number of staff needed to meet people's dependency needs.

However, we received mixed opinions from people and their relatives on how quick staff responded to them/ their family member. One person said, "[The wait for assistance from staff] is two to three minutes unless they are busy with someone else." Another person told us, "They come pretty quickly – no problems with that at all." A third person said, "Sometimes it is a long time. You see it varies sometimes you can wait between five to 10 minutes. When they [staff] come, I ask, when can I get up. They turn off my [call] bell and say things like 'we are just feeding so and so or they say we are just getting other residents up etc etc."

A nurse spoken with told us, "People get up when they want, early or late. Most who want to have breakfast in the dining room are up and dressed." One care staff said, "We do quite a good job with the number of staff we have. Three people are on one to one. We have two agency staff to do that and our staff do the other person. For one to one we do two hourly and we cover for the agency staff breaks. [Staff] holidays are covered [organised] by management. If [staff] sick we help each other out." During this inspection our observation showed that people's call bells were answered within two to three minutes.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The applications for this in care homes are called the Deprivation of Liberty safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the previous inspection, we could not find recorded evidence in one of the care records we looked at of a best interest decision meeting held to discuss a best interest decision, although records indicated that discussions had taken place.

During this inspection we spoke with the manager about the MCA and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. Applications were still in the process of being made for people who required this safeguard. The manager told us that they had identified that people's capacity needed to been reassessed, and where appropriate, applications would be made.

The activities person said, "I have done the training but I don't deal with DoLS but I know about it. We have to be aware of how they [people] are at the time as it can change. Behaviour can change as a result of infection [for instance]. We take and assess each day and deal with it. We know how people respond if they understand what we are asking [them]. We [staff] would ask in a different way and see what their response is. Having [a] 'this is my life' [document in the care records] gives you a good idea of what they [people] can do and what they used to be able to do. Best interest is when we do something in resident's [people's] best interest, like having cot sides [bed rails] up to prevent people falling out of bed."

One nurse said they had completed MCA training and there was another session due to be completed the following week for all staff. The nurse said, "I have done the e-learning then we have 'proper' training. The manager has asked for someone to come [to the service to do more training in MCA]. Capacity of a person is [for them] to make [their own] decisions. There is information in the care plans about it and we assess the resident [person] as often as necessary. [People] have regular reviews and involve other staff to observe and report [on their behaviours and level of confusion]. We record if there have been any changes in condition and do another MCA assessment. If they do not have capacity then we involve the next of kin and GP."

Five out of eight people who used the service and their relatives told us that they were happy with the food served in the home. One person said, "The food is good nearly all of the time…we get fresh vegetables and

fruit." Another person told us, "It's great yeah! We get a four week menu which gives a variety. It is mostly hot and we do get vegetables." A relative said, "The food is fabulous." A third person told us, "The food is extremely good. You get a choice of two or three things. We can ask for a drink [at any time]. I would have no trouble asking, and I would get one." However, a fourth person told us, "Well it's alright. I have got used to it now." Another relative told us that their family member had a specific health condition and that they were worried about the food being served. We spoke with the manager about this during the inspection and they have liaised with the relative and their family member to resolve this.

We saw that people were provided with a selection of hot and cold drinks and snacks throughout the day. Our observations during the meal time showed that people could choose where they wanted to eat their meals. Some people chose to eat in their own rooms and this choice was respected by staff. This showed us that staff supported people to maintain their own independence.

Staff told us about the recruitment process that had to be completed before they became a staff member. They said that when they first joined the team they had an induction period which included training and shadowing a more senior member of the care team. One staff member told us, "My induction was one month. The senior carers teach us." This was until they were deemed competent and confident by the manager to provide effective and safe care to the people they assisted.

Staff members told us they enjoyed their work and felt supported. Staff said they attended staff meetings and received formal supervision and appraisals of their work. One staff member said, "I get supervision every three months and a yearly appraisal. They ask what we are doing for the residents, what we want to be doing in five years." Another staff member said, "We are quite lucky with our support system and management." Staff told us that staff meetings and supervisions were a, 'two way process' which meant that they were able to use this time to discuss anything that they wished to. This showed us that staff were supported within their job roles.

The majority of people who used the service and relatives were complimentary about the staff. One person said, "[Staff] they all know what they are doing, just a few [staff are] more difficult to understand than the others, but they are all knowledgeable." Another person told us, "As far as I can tell they are well trained – no problems." Staff told us about the training they had completed to make sure that they had the skills to provide the individual care and support people required. This was confirmed by the record of staff training undertaken to date. A nurse said, "I have done my moving and handling [transferring]. It was done very well. We do the e-learning first and then specific [classroom] training. I have had tracheostomy training… someone from outside came in to train us and then we had to be observed three times before we could be signed off [as competent] to use it independently." One care staff told us, "I have just completed training in the use of thickeners [in fluids]. I have completed all my e-learning, like moving and handling, mental capacity act and fire [safety] as well as the use of fire extinguishers."

Records showed us that training included, but was not limited to; infection control; equality and diversity; MCA and DoLS; dementia awareness; safeguarding and health and safety. We also saw training undertaken on, equality and diversity; food hygiene awareness; basic life support; medication awareness; fire prevention and awareness and moving and handling safely. We also saw evidence that some staff had attended training on catheter care. We also saw a letter from a local university commending the management team for their high quality mentorship of students from the university who were completing their qualification's in health and social care. This showed us that us that staff were supported to develop and maintain their knowledge and skills.

Records showed that staff involved and referred external healthcare professionals if there were any concerns

about the health of people living at the home. We saw documented evidence of GP visits and dietician involvement. We overheard one staff member ask a person, "Are you seeing the physio today?" Records showed that this person had regular appointments. Staff told us that if they found a person's health deteriorating they told us the nurses on duty and as a result the GP; physiotherapist; speech and language therapist or other NHS bodies were called. One relative said, "[Family member] in the [named number of days] she has been here, she has seen the doctor twice. They are very good with that." This showed us that staff referred people to external healthcare professionals when needed.

Requires Improvement

Is the service caring?

Our findings

After this visit we received concerns about some staff who were not supporting the people they assisted in a kind, caring and dignified manner. During this inspection people who used the service and their relatives told us that staff were caring and polite. Our observations throughout the visit showed evidence of kind and patient interactions by staff but some staff were less so. One person said, "The carers are all very good and kind. I need them to help me to get showered and they are very kind and patient with that." A relative told us, "The care is very good, personal care is good and helps retain [family members] dignity. Staff look after me as well as my [family member]." However, another person told us, "Some [staff] take a lot longer than others but they are kind and patient with me – well one is a bit snappy." We saw some staff members crouching down to make eye contact with the person they were supporting to try to reduce the person's anxiety or to show respect. We also overheard how staff spoke with people in the home. This was done in a respectful and caring manner. We heard how people were addressed and checked that people's choice of address was correct, which it was. One staff member said, "We all get along so well, it's like a family."

We observed some missed opportunities for staff to engage with the people they supported in a caring and engaged manner. We noted that some staff did not always speak or respond to the people they assisted. For example, we saw occasions when the lunchtime meal was placed down in front of a person by some staff with little or no interaction. Meals were not always explained to people by some staff and some staff did not appear to check whether the person was happy with their choice of food. One person told us, "We don't really get a choice [of food] in our rooms we just eat what's put in front of us, but I can't complain." This indicated to us that there were some missed opportunities from some staff working at the home to make the mealtime experience a meaningful and enjoyable social experience. We gave some examples of what we had seen to the manager during the inspection who told us that they would look into this and make the necessary improvements.

Our observations showed that during this inspection people's dignity was respected. We saw that there were signs on people's bedroom doors that indicated to other staff and visitors/ relatives that personal care was being provided to that person. We saw and heard how staff knocked and waited for people to give permission before they entered their bedrooms. One nurse said, "Staff must have respect for people. We ask when we are doing personal care. We shut the door, ask the resident [person] if they want a male of female [staff member] and offer choice in things like clothing, where to go, what time to get up or go to bed. Also what to eat, activities, we give lots of choices not just one." A person confirmed to us that, "[Staff] put the towel over me when they give me a wash on my bottom half which they do before they get me up, or if I have a bath on a [named day], they cover my lap with a towel in the chair. No problems at all."

We noted that people were supported by staff where needed to be appropriately and cleanly dressed. People's rooms were personalised with their own possessions. We saw that efforts were made by the manager and staff to make a person's room feel personalised and homely.

Care records had been written in a way that promoted people's privacy, dignity and independence. Staff had endeavoured and succeeded in collecting personal information about people living at the home. This also

included their individual likes and dislikes, any preferences they had, and their individual support and care needs. Care plan reviews took place to make sure that people's care and support plans were up-to-date and met people's current needs. One staff member said, "We rely on family to tell us things that people like and dislike. We keep people as independent as possible. We offer them lots of choice like food, we offer and show people clothing and give them options." However, our observations showed that some staff did not always give people a choice or engage with them.

We saw that where 'do not resuscitate' directives had been completed all necessary information had been completed and was correct. For example the address of the home, reason for the decision and signatures from all parties involved. This meant that people were supported with their end of life wishes.

People's friends and family were encouraged to visit the home at any time by the manager and staff and made to feel welcome. One relative said, "I am encouraged to visit at any time, I'm made to feel very welcome."

Good

Is the service responsive?

Our findings

On the day of inspection there was a 'beach day' where a barbeque had been set up, tents to include sand pits and deck chairs, miniature donkeys that also came into the home for people unable to pet them outside and ice creams. People were very happy to see the donkeys and discussed them before they arrived.

One person told us, "The staff are very nice and kind. I'm very happy here except when I'm in a mood, which is not often. There are lots of books available to read [which I enjoy]. There is a nice garden that we sit in in the summer when there's good weather. It's pleasant here, look at the surroundings. There is a bird table. We play bingo and skittles. There is an occasional party like there is today. We had tea and cakes yesterday." Another person told us their relatives often visited and took them out. However, a third person said, "There is bingo and quizzes but not much at all really, occasionally a singer comes in but … you need more stimulation."

The activities person we spoke with told us there were two full time and one part time activities staff. They covered seven days a week and covered each other for holidays and sickness. She told us there were activities each day on both floors, although the musical entertainment was usually on the ground floor but everyone was able to attend if they wished. She said, "Our clientele [each person] is very different. We try to do 1-1 activities with people who spend their time in their rooms. Everyone gets a weekly activities programme." We saw that people had the programmes in their bedrooms as well as on noticeboards throughout the home. She went on to say, "We have PAT dogs, carpet bowls and poetry reading. Today we are having bingo in the conservatory and a beach party with candyfloss and miniature donkeys." She told us that when people came in to the service the family were asked to complete a 'this is your life' so that staff had information about people's interests, their previous work and other activities they enjoyed. She said, "We like to try and pair people up with other people to keep them socially active. When people click it encourages them to take part [in activities in the service]. We encourage people to eat in the dining room and sit with people who have similar interests."

Care and support plans were developed by staff in conjunction with the person, and/or their family. These provided guidance and prompts to staff on the care and support the person needed and their wishes. The individual support that people received from staff depended on their assessed needs. Support included assistance with their personal care, prescribed medicines, and meal time support. Reviews were carried out to ensure that people's current care and support requirements were recorded, updated and met the persons current care needs. One person said, "I have worked really hard with them [staff] to get documented in my care plan all the exercises and needs I have." This was then used as information and guidance for the staff that supported them. Care staff told us that the nurses gave them information about any new people who moved into the service and other information would be in the communication book.

Records looked at showed that the provider had received compliments about the quality of the care provided. One relative wrote, "Thank you so much for the excellent care you gave to [family member] whilst she was with you."

However, people who used the service and their relatives had mixed opinions on whether they felt listened to if they raised a suggestion or complaint. One relative told us, "They [staff] are very approachable – especially the manager. I don't like to bother him with questions, but he has been very good." Another person said that they had contacted the management team with a concern and were awaiting a response. Staff demonstrated to us that they knew the process for reporting concerns or complaints. Records showed that complaints received had been responded to in a timely manner and resolved where possible.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place. A new manager was in place and they told us that they were currently applying to the Care Quality Commission to become the registered manager. The manager was supported by care staff and non-care staff. One nurse said, "The manager is brilliant. He's the reason I came here [to work]. He is professional and knows how to speak to everyone. The deputy is also very good. They give us lots of support." One member of care staff said, "We have a good manager, if we have a problem we talk and he solves the problem." A new initiative had been introduced by the manager called a 'Hinton hero'. This was an opportunity for staff to nominate a colleague who they thought had gone 'above and beyond' whilst working. This was in place to show staff recognition and to support them.

People who used the service and their relatives told us that they knew who to speak with, and that the new manager was approachable. They described how the manager stops to talk to them in the corridors on in their own rooms, or spoke to them in the communal lounges. One person told us about the manager and said, "We meet him often enough, [although] I don't know his name." However, people said that they didn't always fell listened to when speaking to staff. One person said, "I have told the nurses I like my room door open, but someone keeps shutting the door. I have been very upset about it but you don't get anywhere."

We were told that there were regular staff meetings every month as well as daily meetings with management and senior staff on the floor. The information was then shared with other staff on duty. Staff confirmed that was the case. One said, "We talk about the residents [people] and us. [For example] if a person [has behaviour that challenges themselves or others] we talk about how to prevent the behaviour and give them a good life. Things [ideas] we bring in are discussed and then [put into practice] we do it." One nurse said, "Any issues to improve [the service] or an idea of how to improve people's quality of life are listened to and used [where applicable]."Another staff member told us, "We are quite lucky with our support system and management. The ethos is that we look after people and they have a good life. We look after their families too. A third staff member said, "The managers are brilliant, always welcoming and listen to us. They're brilliant with the residents too." However, we also received information of concern that indicated to us that the manager and management team were not always aware of the day to day staff culture. For example, some staff were found to be not as caring and engaged as they should be when supporting people.

To aid with communication we saw that the management team had introduced a newsletter for relatives which updated them on the home, introduced new staff members and any up and coming activities planned. A 'family forum' had also been held in July 2016. This meeting was held to discuss the changes to the home planned which including, but not limited to; any planned refurbishments and to introduce the new management team.

Quality monitoring systems were in place to monitor the quality of the service provided within the home. These checks included, but were not limited to; a falls working group that looked at the number of falls within the home and the reasons why; health and safety audit; the management of people's prescribed medicines; people's care plans; clinical review audits; home manager walk around audit; infection control; and the review of all accidents and incidents. We saw that any improvements needed were documented as

either completed or being worked on and that these were recorded in an action plan. This showed us that there were processes in place to monitor the quality of the service provided.

The manager had an understanding of their role and responsibilities. They were aware that they were legally obliged to notify the CQC of incidents that occurred while a service was being provided. Records we looked at showed that notifications had been submitted appropriately to the CQC in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We could not be assured that people received their medicines as prescribed. There were gaps in the recording of people's medicine administration and a lack of information on any action taken by staff members. This was not in line with the provider's medication policy. Medicines that could be administered for people by staff 'as needed' did not have robust or detailed protocols in place and there was a lack of information about medicines that were to be given covertly.