Bingley Wingfield Care Limited

Bingley Wingfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 21 July 2015 and was an unannounced inspection. On the date of the inspection there were 38 people living in the home. Bingley Wingfield provides accommodation and nursing care for up to 44 people at any one time. Accommodation in spread over three floors. The client group was mainly older people, some of whom were living with dementia.

A registered manager was in place. 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.

Summary of findings

People told us they felt safe in the home and did not raise any concerns over their safety. Staff understood how to identify and act on allegations of abuse to help keep people safe. Where safety related incidents had occurred we saw the service had fully investigated and put measures in place to prevent a re-occurrence.

Although we found some risks were appropriately managed, we found two risks to people's health, safety and welfare which were not adequately controlled. One person with diabetes was not supported to eat safely and some window restrictors on upstairs windows were not sufficiently secure to protect people from the risks of falls.

Safe recruitment procedures were in place to ensure staff were of suitable character to care for vulnerable people. Although we concluded there were enough staff in the building, their deployment could have been better organised to prevent people in some areas of the building experiencing delays in personal care.

People received their medicines safely at the times that met their individual needs. Medicines were appropriately stored. However stocks of medicines were not consistently logged and monitored which meant all medicines were not accounted for. There were no protocols in place describing when staff should support people with "as required" medicines which meant there was a risk of inconsistent administration of these medicines.

We found staff demonstrated a good level of skill and knowledge of the subjects we asked them about. Staff received training in a range of areas to help them deliver effective care. Shortfalls in staff knowledge were addressed through group and individual training sessions.

The service was acting within the legal framework of the Mental Capacity Act, including meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). A number of DoLS applications had been made where the service judged it was depriving people of their liberty. This helped to ensure people's rights were protected.

People generally told us the food in the home was good and we saw people were provided with a range of food and drinks throughout the course of the day. However nutritional supplements were not appropriately managed as we saw them shared amongst service users rather than given solely to the person they were prescribed for. We also found one person at risk of malnutrition was missing a nutritional care plan and other nutritional care plans did not contain enough information on people's individual needs and preferences.

People and relatives generally told us that staff were kind and caring and treated them well. We saw some kind and compassionate interactions between staff and people who used the service, however this was not consistently the case, some interactions we witnessed lacked respect towards people who used the service.

People's healthcare needs were fully assessed to enable staff to deliver appropriate care. Although we found a range of care plans were in place there was a general lack of information on people's social needs, life histories and preferences which demonstrated their needs were not fully assessed in these areas. This risked that staff may not have sufficient information to ensure they delivered personalised care.

A range of activities were provided to people who used the service through a dedicated activities co-ordinator. People generally spoke positively about the activities on offer.

Complaints were appropriately managed. We saw evidence complaints were logged and responded to promptly. Complaints were reflected on by the service to ensure learning and continuous improvement.

We found the provider had made a number of improvements to the service since the service came under new ownership in 2014. This included changes to the environment, training and the introduction of new policies and procedures. Plans were in place describing further improvements scheduled to the service in the near future, demonstrating a commitment to continuous improvement.

A range of audits and checks were undertaken and we saw evidence these were regularly identifying issues to help continuously improve the service. However we found a number of areas where checks were not sufficiently robust, for example care plan audits, medication audits and checks on bed rails and window restrictors.

Summary of findings

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

Summary of findings

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. Although people told us they felt safe, we found some risks were not appropriately managed.

Appropriate arrangements were in place to ensure people received their prescribed medicines. However stock levels were not routinely monitored and logged.

Staffing levels were sufficient. However the service could have better organised how staff were deployed.

Is the service effective?

Requires improvement

The service was not always effective. People told us the food was good, . however nutritional risks and people's supplements were not always managed appropriately.

We found the location to be acting within the legal framework of the Mental Capacity Act, including meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff had a good understanding of the topics we asked them about indicating that the training they received was effective.

Is the service caring?

Requires improvement

The service was not consistently caring. Most people said staff were kind and treated them well and staff had a good understanding of the people they cared for. Although we observed some kind and compassionate interactions between staff and people who used the service, we observed some situations where staff could have improved the manner in which they interacted with people.

There was also a lack of care plan review involving people or their relatives although we saw this was being addressed.

The home had systems in place to provide compassionate end of life care.

Is the service responsive?

Requires improvement

The service was not always responsive. People had a range of care plans in place which demonstrated that their healthcare needs were fully assessed and appropriate care delivered. However there was a lack of information recorded on people's social needs, likes, dislikes and preferences.

The home provided a range of activities which were generally well received by people who used the service.

We found complaints were appropriately managed and responded to and these were used as an opportunity to improve the service.

Summary of findings

Is the service well-led?

The service was not always well led. A range of audits and checks were completed by the provider and manager. However, we found some instances where the service was not following its own policies and procedures in carrying out the required audits.

We saw evidence that the provider was committed to continuous improvement of the service and had invested significant resources to driving improvement in a number of areas, including training and the premises.

Accidents and incidents were appropriately investigated and action taken to try and prevent re-occurrences.

Requires improvement

Bingley Wingfield 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.

The inspection took place on 21 July 2015 and was unannounced. The inspection team consisted of three inspectors and an Expert by Experience . An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with eleven people who used the service, six relatives, a registered nurse, five members of care staff, the cook and activities co-ordinator. We spent time observing care and support being delivered. We looked at nine people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to our inspections we normally ask the provider to complete 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 improvements they plan to make. We did not ask the provider to complete a PIR on this occasion. We reviewed all information we held about the provider. We contacted the local authority to ask them for their views on the service and if they had any concerns.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home and nobody raised any safety related concerns with us. Care records contained detailed assessments regarding how staff should manage potential risks to people's health and wellbeing, such as falls, nutrition and skin integrity. We saw these were reviewed monthly and where people's needs changed this was reflected within the care records. We observed care and saw some examples of staff being familiar with people's safety risk assessments for example ensuring that wheelchair lap belts were fastened as per the plan of care. However this was not consistently the case and we found two risks which were not adequately controlled by the service. Firstly, care staff were not following risk assessment guidance to ensure risks to one person were safely managed. Their nutritional care plan stated they should be encouraged to avoid sugary foods to help control the person's diabetes. However, during the morning of our inspection we saw care staff gave this person two plates of high sugar biscuits. When we raised this with the deputy manager they agreed it was inappropriate and addressed the issue with the care staff involved.

Secondly, window restrictors in some bedrooms above ground floor were of the type which could be easily bypassed by simply unhooking them. They therefore did not conform to current health and safety guidance. This meant people were not adequately protected from the risks of falling from windows above the ground floor.

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

Emergency evacuation plans were in place to help staff safely evacuate people in an emergency.

The manager and staff we spoke with had a good understanding of safeguarding and how to report and act on concerns. Where concerns were identified such as medication errors we saw these had been logged as safeguarding issues by the service and fully investigated to help protect people. Investigations were thorough and objective to help ensure all facts were established and to help drive learning and improvement from untoward events.

We undertook a tour of the premises. The building had measures in place to restrict access to hazardous areas such as staircases. There were adequate numbers of communal areas available for people to spend time including a newly opened terrace garden area which provided a secure place for people to spend time outdoors. Discussions with the manager and documentation showed that the home was partially through a programme of significant investment in the building which aimed to improve the environment. A significant numbers of bedrooms and some communal areas had so far been completed and these were pleasant and homely. Some other areas required attention for example the décor on the lower ground floor where the carpets were stained. However we were assured by the plan that these areas would be prioritised in the near future. Three maintenance workers were employed who operated a system to ensure building faults were reported and promptly repaired. Regular checks and maintenance of safety related building systems such as fire, water, electrical and gas were in place to help keep people safe.

We spoke with the manager about staffing levels in the home. The manager and records showed that a number of staff had been recently recruited which had reduced the use of agency staff by the home. We received some comments from people and relatives that there had been too many agency staff, for example one relative told us, "I think the trouble is they get a lot of agency staff here and they don't know their likes and dislikes." Another person told us, "There is too many staff who are not regulars." A third relative told us "They went through a spell of agency staff. The situation is sorting itself." Records showed a recent reduction in agency staff being used in the weeks prior to our inspection. This provided us with assurance that these issues were now resolved.

We observed care and found on the whole call bells were promptly answered. Staff were generally visible and available to attend to people's needs. Most people and relatives we spoke with felt there were enough staff, although it was mentioned by people that downstairs there were often not enough. For example one person said "Enough staff? For a majority of the time, yes. Occasionally, there are times downstairs where I've not seen anyone for 20 minutes." This concluded with our own observations of care practice in that there were sufficient staff within the building, but we found staff were not always deployed in a way which enabled responsive support to be consistently

Requires improvement

Is the service safe?

provided. For example, during the morning of our inspection the activities coordinator was based in the downstairs dining room. During this time there was no care staff present, despite there being up to 16 people in the room enjoying a game of bingo. As people were spread across four different tables we saw this meant the activities coordinator found it challenging to spend time with each person to provide the encouragement and support they needed to enjoy this activity. We also saw that without care staff present when people needed support with personal care the activity coordinator had to press the buzzer and wait for care staff to attend. We saw this meant one person waited over 45 minutes to be supported with personal care. We raised this with the registered manager who said they would review the arrangements in place for how staff were deployed within the home as an immediate priority.

Some people expressed concerns with us about the timing of the medication rounds. For example one person told us, "Medicines are coming at odd times, sometimes it's nearly lunchtime and they should be at breakfast." Another person said at 10.15am, "I haven't had my tablets yet". We observed the morning medication round took a long time to complete and was still being done at 11.50am. We asked the registered manager to look at how this could be done in a more timely manner. The nurse responsible for administering medicines had a kind, patient and caring approach and ensured they followed best practice when encouraging people to take their medicines. For example, we saw they explained to each person what their medicines were, patiently waited with each person until they had taken their medicine and used medicines administration records (MARs) to check which medicines people were prescribed and to record whether people had taken or refused their medication. Arrangements were in place to ensure medicines were given in line with the prescribers instructions. For example, some people were prescribed a medicine which should have been given prior to food. We saw this was given by the night staff before the main medicines round so that people could have it before their breakfast.

Records of medication administration showed people received their medicines as prescribed. Medicines were stored appropriately, a new medicine room had recently been commissioned due to problems with the temperature in the old room. Controlled drugs were appropriately stored and managed.

Overall we found medicines were safely managed. However, some elements of the medication management system were not adequately robust. We found the amount of each boxed medicine was not recorded when it entered the home and routine stock balances were not kept. This meant that there was a lack of accountability for medicines and the home would not be able to identify if tablets went missing. We also found there were lack of "as required" protocols, to guide staff on when people required medication used to control distress or pain although we did see staff followed the correct practice in asking people whether they were in pain before giving out as required (PRN) pain relief. We found these two issues contradicted the provider's medicines policy showing that on these issues, the service was not following its own policy. When we raised this with the registered manager during feedback they told us they would take immediate action to address.

We recommend the service seek advice and guidance from a reputable source to ensure appropriate arrangements are in place regarding their management of medicine stocks and to ensure clear protocols are in place regarding 'as required' medicines.

Robust recruitment procedures were in place to ensure staff were of suitable character for the role. This included checking previous work history, ensuring they were subject to a DBS (disclosure and baring service) check and obtaining references. This helped to ensure people were cared for safely by staff.

Requires improvement

Is the service effective?

Our findings

People generally spoke positively about the care provided. For example one person told us, "We're quite satisfied how my relative is being looked after."

People and their relatives told us staff had the correct skills and knowledge to care for them although some concerns were expressed about agency staff not knowing people's individual needs. We found staff received a range of training and demonstrated to us a good level of skill and knowledge about the subjects we asked them about. Training was provided as part of an annual training programme which included dementia, safeguarding, manual handling and food hygiene. Although some staff were overdue training updates, we saw a plan was in place to address this over the coming months. Training was delivered face to face and it was clear the service had taken the time to plan high quality training delivered by people with an appropriate level of expertise. Specialist training had been provided to some staff which included end of life care, catheter care and diabetes. This helped staff to deliver effective care in these areas.

Individual and group supervisions had been done to address deficiencies in staff skill and promote subjects such as accident reporting, the Mental Capacity Act and infection control. However we did note that staff did not have regular structured supervisions, although the manager told us this was something they were planning to introduce in the near future. Some staff appraisals were also overdue but we saw there was a plan in place to address these by August 2015.

People we spoke with were largely content with the food they received, for example one person told us, "The food is fine." Another person told us, "The food is a bit rough and ready, but it's quite good." Some people commented that when the cook was not present the food quality dipped, for example one person told us, "When we have a proper chef it's nicely done" and another person told us, "It depends who the cook is. If the cook is off, it doesn't go down well." We saw through discussions with the manager that there had been some issues staffing the kitchen but they told us this was now resolved.

During our visit we observed breakfast and lunch. We saw staff provided encouragement and support to assist people to eat and drink during mealtimes and throughout the day.

We saw that breakfast was well paced. People were offered a choice of drinks, cereals, toast and a cooked breakfast. We saw people were promptly provided with their choice and staff gave encouragement and appropriate support to ensure people ate and drank sufficiently. However we found some aspects of the mealtime experience could have been improved. When the lunch trolley was brought into the dining room we saw people were asked which of the two menu choices they would prefer. However, people were not shown the food on offer to help them make an informed choice. The people who lived with dementia would have benefitted from a visual prompt to assist them in making their decision. When the main course arrived, as it had apparently arrived a little late, staff stood around waiting for the hot trolley and missed the opportunity to serve drinks before the meal arrived, as a result they arrived mid-meal. There was then a very long gap after the main course before the desserts arrived which made some people a bit anxious.

Some elements of the mealtime experience appeared to be part of staff's routine, rather than the preference of the people who used the service. For example, before lunch was served we saw one staff member put a clothing protector on the table in front of every person. Another staff member went round every table and put these on each person without asking if people wanted to wear one. From our observations we saw clothing protectors may not have been appropriate for some people. One person told us, "We are always given one so I just wear it, I probably wouldn't if I was given a choice." Some people also told us they felt the evening meal was served too early. They said sometimes they wouldn't finish lunch until 1.30pm but may then be served their tea at 4pm. We spoke with the registered manager about this who said they would review the timing of meals with people who used the service.

People were provided with drinks and snacks at regular intervals and we saw staff regularly prompted people to drink extra fluids due to it being warm on the day of our inspection.

From the records we reviewed we saw that people's weights were stable. Where risks were identified people were monitored more frequently to ensure their nutritional needs were met. We also saw that people were referred to their GP if they began to lose weight. However, we saw some missed opportunities to ensure nutritional risks were effectively managed and ensure people were provided with

the necessary support. For example, one person assessed as being at a high risk of malnutrition had only eaten half of their main meal during lunch. Staff tried to encourage them to eat more but they pushed their plate away. They were brought a bowl of ice-cream for dessert which they quickly ate and then began to scrape the bowl with their spoon. This showed us that they may have wanted some more ice-cream. However, their bowl was taken away without staff offering them another portion. This could have been an opportunity to ensure this person consumed additional calories. A relative also told us that due to problems their relative had with eating, "It would be beneficial if someone could help her to eat as she doesn't enjoy her food. It's most important that my relative is fed properly. They say they haven't the time. The food is not always hot enough. It gets cold if they leave it."

We spoke with the cook who had a good understanding of how to cater for people's dietary needs and preferences. They explained they always looked for opportunities to fortify foods to help ensure people consumed sufficient amounts of calories. For example, they explained the mashed potato served on the day of our inspection was made with full fat cream and butter.

We found people's prescribed nutritional supplements were not being appropriately managed. We saw most nutritional shake supplements given on the morning of our inspection were taken from the same box, rather than each person being given their nutritional shake from their own prescribed box of supplements. Although the product was the same, supplements should be managed in the same way as any other prescribed medicine so that stock levels and people's intake can be appropriately monitored. The current arrangements in place for managing people's dietary supplements risked that people's nutritional needs may not be fully met. We spoke with the registered manager about this and they said this would be addressed as an immediate priority.

We saw individual preferences were catered for. For example, one person was served pickles with their breakfast as this was what they said they enjoyed. However, care records did not always contain comprehensive information regarding people's dietary preferences. For example, during lunch we saw one person was given liquidised cauliflower cheese, mash and gravy. We asked care staff and the cook about this person. They told us this person preferred a mashed or soft diet and if they were given food they had to chew they would not eat it. They had been referred to their GP for this and had been prescribed nutritional supplements which they were being given. However, there was no information about this person's preference for soft and pureed foods within their care records. We also identified that one person whose malnutrition risk assessment assessed them as being at risk, did not have an eating and drinking care plan in place detailing how staff should support them to maintain good nutrition. We reviewed their weight and saw it was stable. However the lack of care plan went against the MUST tool (malnutrition universal screening tool) recommendations. This meant there was a lack of arrangements in place through the presence of robust care plans to meet the nutritional needs of service users.

Overall we found that appropriate arrangements were not in place to ensure people's nutritional needs were consistently met. This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was information within care records so staff could support people to maintain good health. For example, one person who lived with diabetes had specific care plans and risk assessments in place to help staff manage this condition, such as a care plan for diabetic foot care. People and relatives reported that systems were in place to ensure that people had access to a range of health professionals to help them maintain good health.

We found the manager had a good understanding of Deprivation of Liberty Safeguards (DOLS) and the Mental Capacity Act which gave us assurances that the correct legal processes were being followed. Expertise in the subject had been disseminated from the provider to the manager and other staff via a programme of supervision and training. We found this had been effective in giving staff the required skill and knowledge on the subject. Where people lacked capacity to make decisions for themselves and the home had assessed that they were depriving people of their liberty for their own safety, a number of DOLS applications had been made by the home. This showed the correct processes had been followed.

Where the service suspected people lacked capacity to make decisions for themselves, we saw a capacity

Requires improvement

Is the service effective?

assessment had been conducted and a best interest meetings set up including a multi-disciplinary team. This showed us that the service was working within the guidelines of the Mental Capacity Act

Requires improvement

Is the service caring?

Our findings

People and their relatives generally told us that staff treated them well and were kind and caring.

For example one person told us, “The staff’s marvellous. The staff are all nice. Everybody’s kind to everybody.” Another person told us, “If there’s a problem at night they’re very attentive.” A relative told us, “Everything’s fine. Average – above average. The home’s good. My relative is generally well groomed. Yes, the staff are kind and respectful.”

During our observations we saw some positive interactions for example staff addressed people in a warm and compassionate manner and spoke kindly and patiently to people. When meals came out the cook engaged warmly with people who used the service and talked to them about the food. However during these observations we saw that this high level of compassion and respect was not consistently applied and some staff did not ensure people’s dignity was maintained. For example, we observed that some staff were not discreet when asking people if they needed support with personal care. We also saw some interactions were not respectful and did not involve people in making decisions about the care and support they received. For example, we saw one staff member support one person to move in their wheelchair so they could have their breakfast. As they entered the dining room the staff member shouted across the dining room “Where should we put them?” Another carer replied, “Put them over here.” There was not consultation with the person to ask where they wanted to sit. We also saw examples where staff did not always fully explain the support being provided, such as moving wheelchairs without speaking with people and putting clothing protectors on during lunch without asking people’s permission.

The service made reasonable adjustments to meet people’s individual needs. This included the provision of disabled access into the building, and we saw a visually impaired person being supported to read braille text in the lounge.

The manager understood when it was appropriate to seek advocates to help support people in making decisions and was able to give us examples of when they had helped people to support advocates to ensure their views were represented.

We found mechanisms for formally listening to people and their views could have been improved. People and their relatives had a varying experience of being involved in care plan review. One relative we spoke with was unaware that care plan reviews existed. Another relative told us that care had been discussed when their relative came to live at the home but it had not been discussed since. They said, “No, I’m not involved in the care plan. We’ve never had a meeting about how things are going. It would be good to have a review meeting every 6 to 12 months.” We found that care plans did not contain any evidence of review, although this had been identified by the deputy manager during May 2015 and we saw a plan was in place to ensure everyone was involved in a structured care review in the near future.

Arrangements were in place to ensure people were provided with dignified end of life care. We saw some staff had been provided with training on the subject to give them extra skills in order to provide appropriate and compassionate care.

Requires improvement

Is the service responsive?

Our findings

The home had systems in place to ensure appropriate care was delivered. We observed handover from the night shift to the day shift. We saw it was detailed and thorough and provided staff with good information on each service user to help ensure their needs were met. A range of care plans were in place to help staff meet people's needs. These included mobility, eating and drinking and pressure area. Where specific needs were identified such as behaviours that challenged, individual care plans were put in place. We saw examples that these were followed such as people sat on the correct pressure relieving equipment. Overall we found detailed information in care records about people's healthcare needs. However we found a lack of information about people's social needs. For example, most care records did not have detailed information about people's life history, hobbies, family, culture and spiritual needs. This risked that staff would not be able to provide people with person centred care. We saw it was noted that one person had behaviours that could challenge and we concluded more could have been done to assess their life history and see whether the provision of individualised care to their likes and preferences could assist in this area. Some people and relatives reported that there were some approaches used by the home which were not conducive of good person centred care. For example one relative told us, "You can get up and go to bed only if they're free." Another said, "If you are on the shower list and you are not well, it's missed until the next shower list. You can't have a bath or shower when you want." There was also a lack of evidence that people were involved in the creation and review of care plans although we saw this had been identified by the home as an area to address.

Despite the lack of information present within care records, our observations and discussions with people showed us the care staff present on the day of the inspection knew people well. For example, we saw one person became disorientated and upset and said they were 'lost'. We saw care staff redirected this person back to their 'flat'. When we spoke with staff they told us this person referred to their bedroom as their 'flat'. We observed that when this person was shown their 'flat' and reassured by staff their anxiety reduced and they enjoyed playing a game of dominoes with other people and staff.

We saw both care staff and the activities coordinator worked hard to ensure people received appropriate interaction and stimulation. There was a programme of group activities which on the day of our inspection included a game of dominoes, bingo and a musical entertainer. We also saw staff spent time on an individual basis with people. Some staff sat discussing articles in the paper with people during breakfast and the activities coordinator told us they usually spent some of their time providing individual interaction to those people who preferred quieter activities and to spend their time in their bedroom. The home and its residents also benefited from a volunteer, group 'Friends of Wingfield' who organised events to help meet the resident's social needs.

People generally reported the activities in the home were good for example one person told us, "There are things you can do. Plenty of things to enjoy. We can't grumble. The garden has improved recently." Some relatives thought the range of activities could be further improved for example with more trips out and a lesser reliance on the television. We saw plans were in place to recruit a further 10 hours of activities co-ordinator to ensure a greater variety of activities. This showed the service had recognised this was an issue for people and were responding to address it.

An appropriate complaints system was in place. People generally reported a high level of satisfaction with the service and said they had no reason to complain. One person told us that when they had complained the manager had rectified the problem. We saw three complaints had been received in 2014/15, these had been responded to promptly and solutions offered to assist and resolve the complaints.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in place. We found the provider had submitted all required statutory notifications to the Commission, for example notifications of service user death and serious injury.

People and their relatives generally spoke positively about the way the home was managed and said they were satisfied with the quality of the service. For example one person said, "Yes, the home is well managed." A relative told us, "My relative is very satisfied" and another person told us "All in all we're quite happy". People and staff reported the provider regularly visited and took the time to speak with them to help them understand how the service was running.

Although most comments were positive, some people and relatives said the home could be better organised for example one person told us, "The whole place is disorganised". We concluded some aspects of the service could have been better arranged, for example although we found there were sufficient staff to ensure safe care we found the duties of staff could have been better organised through effective leadership to ensure a higher quality experience for people who used the service. Examples included ensuring sufficient staff were deployed downstairs and ensuring mealtimes were better organised.

Staff reported that they felt well supported by the manager and provider. They told us they were happy in their duties and that things had improved for the better since the change in ownerships of the home in 2014. We saw evidence which confirmed this and demonstrated the provider had made a number of improvements since taking over the service. This included introducing new policies and procedures, making improvements to medication storage arrangements, the general environment and staff training. Where improvements had been recommended by external agencies such as the local authority contracting team, we saw these improvements had been actioned, for example ensuring the service user guide was made readily available for people.

We saw there was good supervision and leadership from the provider in driving up the quality of care and expertise within the home, for example around sharing knowledge on DoLS following a legal ruling on the interpretation of the law in 2014. Although we concluded there were inconsistencies in the quality of care provided by the home, we were assured that the home was constantly identifying and actioning improvements. For example the deputy manager had identified that care plans needed to be more person centred and evidence people's involvement and we saw care plans were in the process of being developed.

A range of audits were undertaken by the service. This included regular provider checks on the quality of the home. These were evidenced through the 'Provider diary system' which looked at areas including medication, infection control, care and welfare, concerns and complaints. Periodic infection control audits were undertaken and we saw evidence action had been taken following the previous external one to improve the environment. The manager also completed a monthly audit which was reviewed by the provider as a mechanism to keep informed on how the home was running.

Staffing levels were regularly monitored. For example we saw minutes of a July 2015 management meeting which showed people's dependency was reviewed to ensure staffing levels were appropriate. This concluded at what resident level/dependency staffing levels should be increased and where carers should be deployed during the shift. However during observations on the day of our inspection, we found issues with staff deployment showing that further management review of this area was required.

Managers meeting minutes showed these were a mechanism to discuss quality issues and improve the quality of the service.

Overall we saw evidence the service had effective governance systems in place and we saw evidence that these were used to drive improvement in the service. However we found a number of areas where quality checks were not being carried out in line with the provider's policies. For example the dignity policy said that the manager should undertake an annual review of compliance with the 10 point dignity challenge but this had not been done. We concluded the home would benefit from this given we found staff were not consistently treating people with dignity and respect. The services care plan policy also stated that three care plan audits should take place a month against a standardised format, however this was not taking place. We found some care records lacked an attention to detail which had not been identified and addressed by an effective system of audit. For

Requires improvement

Is the service well-led?

example, in one person's care records we saw they were called by the wrong name and in another care plan they were missing a key care plan. Bed rails were also not regularly checked as per the services bed rail policy.

We found regular medication audits were taking place. This included controlled drugs, and audits of the documentation of medicines to ensure they were given as prescribed. We saw these effectively monitored some aspects of the medicine management system. However the MAR audits did not record which MAR charts were looked at which meant a full audit trail was not in place. We also found the June 2015 MAR audit stated that a record of all medicines received and quality was noted on the MAR but we found this was not the case. We asked the manager to ensure improvements were made to this audit mechanism.

Accidents and incidents were recorded. We saw there had been a push to staff to encourage them to report all types of incidents through supervisions and direction by management. There were clear outcomes recorded following accidents/incidents which helped keep people safe, and learn from them. We saw evidence care plans and risk assessments were updated following incidents to help prevent reoccurrences. The number of accidents/incidents was analysed each month to look for any trends of themes. However this analysis this did not include analysis of where each incident was happening which would have been useful in identifying if there were any areas of the building where for example falls were more common.

People's feedback was regularly sought through surveys. The manager told us they tried to do these six monthly. We saw feedback was mainly positive. Where issues had been identified we saw evidence appropriate action had been taken to address them. Regular staff meetings were held during which we saw a range of issues were discussed such as care plans, infection control. Periodic resident and relative meetings were also held, which consulted with people over building improvements activities and events.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Care and treatment was not always provided in a safe way for service users as the risks to people's health and safety were not appropriate assessed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Appropriate arrangements were not in place to ensure people's nutritional needs were consistently met. Care plans were not always clear and being followed and dietary supplements were not always being effectively administered and monitored.