Claregrange Limited

Aslockton Hall Nursing & Residential 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 and 7 September 2016 and was unannounced. Aslockton Hall Nursing & Residential Home provides accommodation, nursing and personal care for up to 62 people. On the day of our inspection 53 people were using the service who had a variety of needs associated with dementia and physical health conditions.

The service did not have a 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. Applications had been made by two people to become registered managers.

At our last inspection in March 2016 we found that the provider was not meeting the legal requirements in a number of areas. During this inspection we checked to see if the required improvements had been made.

Assessments of the risks to people's health and safety were not always up to date and steps to mitigate risks had not always been taken. People felt safe living at the home and staff were aware of how to protect people from the risk of abuse. There were sufficient numbers of suitable staff although people sometimes experienced delays in receiving care. Further recruitment was on-going to increase the total pool of staff. People generally received their medicines as prescribed although occasional errors had occurred.

Staff had received recent training to enable them to provide effective care and further training was planned. Staff felt supported and had received supervision of their work. Where issues were noted during supervision meetings these were not effectively followed up. People enjoyed the food and were provided with sufficient to eat and drink. People received support from healthcare professionals, such as their GP, when needed.

People were asked for their consent and staff respected people's right to make decisions. The Mental Capacity Act (2005) (MCA) was not effectively utilised in order to protect people who were not able to make their own decisions about the care they received.

There were positive relationships between staff and people who lived at the home. People got on well with the staff who cared for them. The day to day decisions people made about what they wanted to do were respected by staff. People were treated with dignity and respect and their right to privacy was upheld.

People were provided with the care they needed although staff did not always provide this in a timely manner. Information in people's care plans had improved since our previous inspection although they were not always up to date. There was a range of activities available although some people felt the activities did not match their interests. Work was underway to improve the provision of activities. People knew how to complain and told us they felt comfortable approaching the manager and staff.

The quality monitoring systems used did not always identify issues or result in improvements to the service people received. Staff did not always maintain accurate records about the care people needed or the care they had provided.

There was an open and relaxed culture in the home and the registered manager led by example. People were asked for their opinion about the service they received and their suggestions were acted upon.

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.

Risks to people's health and safety were not always assessed on a regular basis and steps to reduce risks had not always been taken.

There were sufficient numbers of suitable staff to meet people's needs. Further recruitment was on-going to increase the total amount of staff available.

People did not always receive their medicines as prescribed.

There were systems in place to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt supported and told us their training had been effective. Further training was planned. Staff were not always effectively supported through supervision.

People were asked for their consent. Where people lacked the capacity to provide consent their rights were not always protected.

People enjoyed the food and were provided with enough to eat and drink.

Staff ensured that people had access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who had developed positive relationships with them.

The decisions people made about their care were respected by staff.

People were treated with dignity and respect and their privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received the care and support required however information about their care was not always up to date.

Improvements had been made to the provision of activities but further developments were required to better meet people's needs.

People felt able to complain and knew how to do so.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a quality monitoring system in place however this was not always effective in identifying and resolving issues. Staff did not always maintain accurate records about the care they had provided.

There was an open and transparent culture in the home, people and staff felt able to speak up.

The manager led by example and had implemented many improvements.

Aslockton Hall Nursing & Residential 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.

We visited the service on 6 and 7 September 2016, this was an unannounced inspection. The inspection team consisted of one inspector, one pharmacy inspector, a specialist advisor who has experience in providing nursing care 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with eight people who used the service, four relatives, three nurses, three members of care staff, an activities coordinator, the cook, a 'bed maker', the home manager and the matron. We looked at the care plans of six people and any associated daily records such as food and fluid intake charts. We looked at four staff files as well as a range of other records relating to the running of the service, such as audits, maintenance records and the medicine administration records for 15 people.

Requires Improvement

Is the service safe?

Our findings

At our inspection in March 2016 we found that people were not protected from the risk of harm and abuse. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that the improvements had been made and systems were in place to reduce the risk of harm and abuse happening. Information about any incidents that had occurred was being shared with the local authority safeguarding team.

The people we spoke with told us they felt safe living at the service. One person said, "I feel safe – nothing bothers me greatly." Another person told us, "I feel very safe – I've got company here and people to see me." The relatives we spoke with also told us they were confident that their loved ones were safe living at the home. One relative said, "[My relative] is very safe – I go from here with peace of mind." Another relative told us, "[My relative] is much safer than at home."

During our visit the atmosphere was calm and relaxed and people generally got along well together. We observed that people were confident when speaking with staff and everybody was treated in an inclusive manner. Staff told us they were able to manage any situations where people may become distressed or affected by the behaviours of other people. However, people's care plans provided only limited information to staff about the best way in which to manage any situations which may be challenging.

Staff received training and development to understand their role in protecting people from the risk of harm and abuse. The staff we spoke with had a good knowledge of the different types of abuse which may occur and how they would act to protect people if they suspected any abuse had occurred. However, not all staff were aware of how safeguarding concerns should be reported outside of the service, despite a new safeguarding procedure being in place and available to staff. All staff said they would report any concerns to the manager in the first instance. Information about safeguarding was displayed in the home in a prominent position.

At our inspection in March 2016 we found that steps had not been taken to reduce risks to people's health and safety. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that many improvements had been made although further work was required to ensure that staff had up to date information about risks to people's health and safety.

People told us they were generally satisfied with the way in which risks to their health and safety were managed. One person said, "They listen to what I say when moving me and will do it more slowly if needs be." Another person told us they relied on staff to transfer them from one place to another and to keep them safe whilst in their room. They told us that they were satisfied that staff endeavoured to reduce any risks to their safety when supporting them. The relatives we spoke with also felt that staff worked to reduce the risks to people's health and safety. One relative said, "[My relative] is as safe as they can be, given their falls history." Another relative told us, "[My relative] has to be hoisted and I've no concerns. I watch them with other people too and they're very good."

Different risks to people's health and safety had been assessed and measures put into place to reduce risks to people. People's care plans contained tools to assess different risks such as the risk of malnutrition, falling and of developing a pressure ulcer. The assessments we viewed clearly identified risks to each person and what staff could do to support them. For example, one person had been assessed as being at risk of developing a pressure ulcer. Staff supported them by regularly changing their position and checking the condition of their skin. However, two people's pressure relieving mattresses were not set at the correct level, meaning they were not providing effective pressure relief. In addition, risk assessments were not always reviewed frequently, meaning that the correct level of risk may not have always been identified. This meant there was a risk that staff may not have been taking the correct action to reduce those risks.

People lived in an environment that was generally well maintained. Staff reported any maintenance requirements and these were mainly resolved in a timely manner. A programme of refurbishment and redecoration was underway with further improvement works planned. Preventable risks and hazards were minimised because regular safety checks were carried out, such as testing of the fire alarm and actions were taken to reduce the risk of legionella developing in the water supply. One person commented, "I've even seen the fire evacuation plan. They're so conscientious, I feel safe."

At our inspection in March 2016 we found that sufficient numbers of staff had not been deployed to meet people's needs. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that improvements had been made and staff generally responded to people's needs in a timely way. Further work was required to ensure that enough staff were available to cover each shift and in the event of staff sickness.

We received mixed feedback from people about the staffing levels at the home. One person said, "We can find someone usually or ring the buzzer if not." However, another person commented, "They are a bit short at peak times, especially as it can take two of them an hour to get me up, washed and dressed." We also received mixed feedback from the relatives we spoke with. One relative commented, "They've had staffing problems in the last 6 months. [My relative] has missed baths a few times – I spoke and it was put right. It's getting better here now." Another relative told us, "At weekends they're stretched – the care seems to be later, [my relative's] bed isn't made. We see them (staff) rushing around."

During our visit we observed that staff mostly provided the care people needed in a timely way. However, there were occasions were people were not supported within a reasonable time frame. For example, when we arrived on the first morning we noted that five call bells were ringing. These remained ringing for between 20 and 25 minutes, meaning that those people had not received support in a timely manner. Staff were deployed in various parts of the home and ensured that regular safety checks were carried out.

The staff we spoke with told us they felt the staffing levels were only sufficient enough to provide people with basic care and ensure they were safe. However, all staff felt that they could not spend quality time with people due to pressures on their time. In addition, there were not sufficient staff employed to ensure all shifts could be covered. However, more staff were being recruited to address this and agency staff were used where necessary to cover sickness. The manager carried out an assessment of people's needs and based staffing levels on this. They told us they felt that staffing levels were sufficient to keep people safe. The manager also told us that they were considering putting additional staff onto the rota to help out at busier times of the day.

The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in making

safer recruitment decisions.

At our inspection in March 2016 we found that people's medicines were not safely managed and administered. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that improvements had been made and people mostly received their medicines as prescribed. Further work was required to reduce medicines errors and ensure that all appropriate guidance about medicines was provided to staff.

The people we spoke with told us that they received their medicines as prescribed, although there could sometimes be delays in them being administered. Since our previous inspection, a new medicines management system had been introduced in conjunction with a local pharmacy. This had led to improvements in the storage, recording, administering and ordering of people's medicines. Medicines were securely stored in a locked trolley and kept at an appropriate temperature. Controlled drugs were stored and recorded correctly. Controlled drugs are a group of medicines that have potential to be abused and so are subject to more stringent requirements about their storage. Medicines with a limited shelf life, such as eye drops and liquids, had their opening date written on them so that staff would know when they reached their expiry date and could dispose of them.

Differing levels of support were provided depending on each person's perceived ability to manage their own medicines. However, there was not always a robust assessment available of people's ability to manage their own medicines. Staff ensured they explained what medicines they were giving to people and were patient when waiting for people to take them. Staff then recorded whether or not people had taken their medicines, although records were not always made at the correct time meaning there was a risk of a recording error occurring. Records of any allergies people had were present within the medicines administration records. However, staff did not have access to clear guidance about when to administer 'PRN' medicines. These are medicines that should only be administered when required. This meant there was a risk people may receive these medicines when they did not need them.

Staff who were responsible for administering medicines (both nurses and care workers) had their competency to do so checked. When any errors had occurred these were addressed with the individual staff member and steps put into place to reduce the risk of similar errors happening again. We saw that staff received relevant training and support in relation to the management of medicines.

Requires Improvement

Is the service effective?

Our findings

At our inspection in March 2016 we found that staff had not always received the appropriate support through training, supervision, induction and appraisal. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that improvements had been made although further work was required to ensure staff could provide effective care.

The people we spoke with felt that staff were well trained and competent in their duties. One person said, "They're all very pleasant and helpful. I find them all very good." Another person said, "They are trained – I see their badges." The relatives we spoke with also told us that they felt staff were well trained and provided effective care. One relative said, "From what we see, they seem well trained." Another relative commented, "They seem very capable."

Staff had been provided with training since our previous inspection and they told us that the training was of good quality. For example, training had been provided in areas such as safeguarding, fire safety and the Mental Capacity Act (2005) in recent months. There remained areas where not all staff had received the training required to provide effective care. However, there was a clear plan in place for this training to be delivered in the months following our inspection. The staff we spoke with felt that the training they had received had enabled them to carry out their role effectively. Staff also benefitted from training provided by visiting healthcare professionals. For example, training had been provided in tissue viability and maintaining good care of catheters.

The staff we spoke with told us that they felt well supported and received regular supervision of their work. One staff member said, "They (the manager) supports me with anything I am unsure about and I can ask if I am not sure." The records we looked at showed that staff had received a supervision meeting since our previous inspection. However, we noted that many staff were overdue for their next supervision meetings. Two of the supervision records we checked noted issues that had been raised either by the manager or the staff member. These had not been effectively addressed because no further supervision had been provided to monitor progress of the issues reported. New staff were provided with an induction period which included spending time getting to know people living at the home, shadowing more experienced staff and undergoing some basic training.

People were able to be involved in making decisions about their care and provided consent where possible. People told us that staff asked for their consent before providing any care or support. One person said, "They'll ask me if I'm ready before bath time." People's relatives were involved in decision making where the person was not able to be involved themselves. The care plans we looked at had been signed by the person or their relative to confirm their consent.

Where people lacked the capacity to make a decision the principles of the Mental Capacity Act (2005) (MCA) had not always been followed. The 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. We saw that some assessments of people's capacity to make a decision had been carried out and decisions made in their best interests. However, other people's care plans reflected that they lacked the capacity to make certain decisions but no assessment of their capacity had been carried out. Despite training having been recently provided in the MCA, the staff we spoke with could not clearly explain the principles of the MCA and how it should be used to protect people.

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 application procedures for this in care homes and hospitals 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. The manager had made DoLS applications and was awaiting the outcome of these. Staff were aware of how DoLS impacted on the care they provided to certain people living at the home.

At our inspection in March 2016 we found that people were not always provided with sufficient quantities of food and drink. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that the improvements had been made and people's nutritional and hydration needs were met.

People told us they were given enough to eat, although feedback about the quality of the food was mixed. One person said, "I think it's very good. The menu repeats every week or so." Another person told us, "The food is excellent." However, another person commented, "The food can sometimes be bland and I don't always like it." People told us they received enough to drink with one person saying, "I have no worries – they give me a jug of water and I have the odd coffee." Some people told us that they did not get to eat breakfast until later in the morning and that it was too close to lunchtime. The relatives we spoke with felt that people were provided with sufficient to eat and drink. One relative commented that their loved one did not always received the required assistance to eat their meal.

We observed that most people enjoyed their meals and ate most of what was provided. The delivery of food to the upstairs dining room did not appear to be as efficient as downstairs. A staff member commented that meals were not always served hot upstairs. Two people did not enjoy their meals and requested an alternative. One person was downstairs and they received an alternative meal. However, the other person was upstairs and they did not receive an alternative meal. Staff provided support to those people who required assistance to eat their meals and this was done in at the person's own pace. Staff also respected the independence of those people who were able to eat their meals without assistance, ensuring that they had everything they needed in place at the start of the meal.

Staff ensured that people had plenty to drink at meal times and throughout the day. There was a range of different drinks available in communal areas and in bedrooms. However, staff did not always have the time to sit with people to encourage them to drink if required. We noted several occasions where people had fallen asleep or were not able to see where their drink was. The drinks were then later removed having not been fully consumed. Kitchen staff were informed about any specialised diets people may have, such as soft food and low sugar alternatives and these were catered for.

People told us that they were able to see the healthcare professionals they needed and when required, with the exception of dental services. One person said, "The doctor does a Wednesday round here. I've not seen a dentist while I've been here but the optician was here two weeks ago. I paid for a man to do my hearing aids." Another person told us, "They had the SALT (Speech and Language Therapy) people in for advice. The optician has been and I've seen the chiropodist a couple of times." The relatives we spoke with told us that

their loved one was provided with access to any medical appointments required and told us they were also kept updated.

During our visit we spoke with a healthcare professional who told us they had a good relationship with staff and found that they took on board any advice they gave. Staff also ensured that people could see their GP should they have any concerns about their health. Referrals to specialist services were made in a timely manner. For example, staff had concerns about a decline in one person's weight and had contacted a dietician for advice. They had advised that the person should receive dietary supplements to try and boost their calorie intake and this was being provided for them. The manager told us they had found it difficult to engage the services of a domiciliary dental service for people who were unable to visit a dentist in the community.

Good

Is the service caring?

Our findings

The people we spoke with told us they got on well with staff and had good relationships with them. One person said, "They're ever so kind." Another person told us, "They're all very pleasant and helpful. I find them all very good." We were also told, "They're busy but nice to us." The relatives we spoke with also said that staff were kind and caring with one relative adding, "They (staff) are very loving towards [my relative]."

We observed that staff were caring and had developed positive relationships with people. There was a friendly atmosphere and staff clearly enjoyed their interactions with people. Staff spoke with people in a polite way and showed an interest in what they were saying. Staff had a good awareness of people's life histories and their circle of family and friends and enjoyed talking with people about these. Staff also showed concern when people were uncomfortable or distressed. For example, one person was asleep but had moved into an uncomfortable position. Staff gently woke them and provided an extra cushion to support them. Staff also shared a laugh and joke with people when it was appropriate to do so. Staff told us that they enjoyed working at the home and that they valued their relationships with people.

The staff we spoke with told us that they could not always spend as much time with people as they would like. However, staff felt that they still had good relationships with people and had not observed any poor practice from their colleagues. People were able to attend religious services in the home and a service was held during the second day of our inspection which was well attended. While nobody expressed any particular cultural needs, there were systems in place to ensure that these could be catered for. Information about people's preferences with regards their care was recorded and respected. For example, the rota was planned to ensure people's preferences about the gender of care staff were taken into account.

People told us that they were involved in their care planning and making decisions. One person said, "The senior talks things through at great length and I can ask anything." People also told us that the day to day decisions they made were respected by staff. One person said, "I'm a late bird – I like to be in bed at 10pm and up for breakfast at 9.30am – which is a bit late. I choose my clothes to wear." The relatives we spoke with also confirmed they were involved in care planning and decision making where this was appropriate. One person said, "They keep me up to date and have regular reviews. We're not afraid to approach either." One relative commented that they did not see the nominated key worker as often as they would like.

The majority of the care plans we looked at had been signed by the person using the service or their relative. We observed that people were involved in their care on a day to day basis and staff respected the decisions people made. Staff asked people where they would like to sit and if they wished to take part in any activities. People were helped to maintain a level of independence and staff ensured that they remained in control of their care as far as possible. For example, one person could walk but required a lot of staff support to do so. We saw a staff member helping the person to walk in a calm and patient manner that respected the person's choice to try and walk rather than use a wheelchair.

People's care plans contained information about the way in which they would prefer their care to be delivered. The staff we spoke with were able to describe people's care needs in some detail and how these

had changed over time. Staff understood the importance of people being at the centre of any decisions about their care with one staff member commenting, "This is their home and people should decide what to do. We are here to help."

People told us they were treated with dignity and respect by the staff. One person said, "They always knock even when my door is open." Another person told us, "The staff are very respectful, at all times." People also confirmed that their privacy was respected by staff. One person said, "They're very good at privacy for me." We were also told, "I prefer to keep my door closed and staff always ask about that first."

We observed staff treating people in a respectful manner and ensuring that people's dignity was upheld. For example, one person shouted across the room to a staff member regarding a personal matter. The staff member went over to the person and made sure that the conversation was held discreetly. We observed that staff knocked on people's doors and waited to be invited into their room, even when the person chose to have their door left open. People had access to their bedrooms at any time should they require some private time. Visitors were able to come to the home at any time and stay for as long as they wished to. One person confirmed this when they told us, "My family can come when they like."

People were provided with information about how to access an advocacy service. A local representative of a national advocacy service visited the home on a regular basis to meet with anybody who wished to talk with them. We spoke with the advocate during our visit and they confirmed that they were welcomed into the home by the manager and staff and enjoyed a good relationship with them. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in March 2016 we found that people did not always receive care that met their needs and reflected their preferences. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that some improvements had been made although further work was required to improve people's care plans.

We received mixed feedback from people about the care they received. One person said, "They don't come round (to my bedroom) very often to see how we are – they come in, do a job but don't stay or ask how I am." Another person told us, "It's very much tailored for me and I can explain things to them too." The relatives we spoke with also provided mixed feedback about how responsive the care was. One relative said, "If only someone could spend 10 minutes chatting now and then, [my relative] would feel happier." Another relative told us, "I don't feel [my relative] could get any better care."

During our visit we observed that staff provided people with the care and support they needed, although staff did not always recognise when people required support. For example, some people had drinks placed next to them but were not able to drink independently or required staff to encourage them. Staff did not always provide this support in a timely manner because they were focussed on their next task. Where people had nursing care needs these were provided for and the nursing staff had a clear system to ensure any treatment was provided when needed. For example, there were clear records about catheter care and maintenance.

People's care plans were in the process of being rewritten into a new format. The manager told us that this had been a large undertaking and that further work was still required to bring all care plans up to the required standard. We saw that care plans generally contained sufficient detail to enable staff to understand people's needs. However, they were not always kept up to date because staff did not always have the time to complete care plan reviews. One care plan had not been reviewed for four months and others for two months. There was a good system in place to hand over information between staff at the shift handover. Staff told us they had enough information to care for people well and could read the care plans if required.

The people we spoke with provided mixed feedback about the provision of activities in the home. One person said, "One of the reasons we chose here was the nice garden – it's a shame not to use it. The first floor is a disadvantage here." Another person told us, "No, there's not enough (activities). We have entertainment on a Wednesday and sometimes Thursday. We can sit in the day room – 7 of us were sat and no-one spoke to each other all afternoon." We were also told, "I belong to the Garden Club and we had a lovely boat trip. Not everyone wants to join in things here though. I've made a few friends and we walk in the garden." The relatives we spoke with also provided mixed feedback about the provision of activities. One relative said, "I've suggested to staff that they turn the lounge TV off sometimes and have music but it hasn't happened. They just sit all day."

The service employed an activities co-ordinator and they told us that they planned activities based on people's known interests and hobbies. However, their hours and working days were limited. On the day of

our inspection care staff provided some activities, for example a game of skittles was played in one lounge. Staff told us that they generally did not have the time to provide activities because they were busy providing care. One staff member commented, "I would love to spend more time with people but at the moment it is not really possible." Since our previous inspection some external outings had been carried out or planned for future dates. There were also occasional events held in the garden, such as a garden party.

The people we spoke with told us they would feel comfortable making a complaint and knew how to do so. Some people gave examples of complaints they had made. The relatives we spoke with also confirmed they were able to raise complaints. One relative commented, "Anything I've mentioned has been dealt with – like [my relative] missing their baths."

People and their relatives had access to the complaints procedure which was displayed in a prominent place and also given to people on admission to the home. We looked at the records of complaints received since the previous inspection. We saw that these had been dealt with in a timely manner and communication was maintained with the complainant throughout the process. Appropriate responses were sent and an apology offered where the quality of the service had dropped below an acceptable standard. The manager also put measures into place to address each issue that was raised to try and prevent similar incidents happening again.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in March 2016 we found that the systems in place to monitor the quality of the service and act upon people's feedback were not fully effective. The provider sent us an action plan detailing the improvements they planned to make. At this inspection we saw that some improvements had been made although further work was required to fully embed the new quality monitoring systems that had been introduced.

The people we spoke with were aware of the different ways they could give their views about the quality of the service. One person said, "I had a questionnaire recently – I stressed staff shortage and call bell times." The relatives we spoke with also confirmed that they had been given the opportunity to complete a questionnaire. One relative commented, "We did a residents' questionnaire with [my relative] recently."

Satisfaction surveys had recently been distributed to people and their relatives and these showed that there was generally a high level of satisfaction with the quality of the service. In addition, there were regular meetings where people were encouraged to voice their opinion. Where people had raised any areas for improvement these were acted upon. For example, some people had mentioned issues with the laundry and the food choice and steps were taken to resolve the issues raised. However, other issues raised were not acted upon so quickly. For example, some people commented on the noise created by the call bell system. During our previous inspection we noted that the call bell system was not fully effective. However, this system was still in use and no steps had been taken to make improvements or mitigate the effect of the noise on people.

The manager had introduced a new auditing system to monitor the quality of the service being provided. Monthly checks were carried out of infection control practice and medicines administration amongst other areas. People's care plans were also audited, however this had not picked up that care plans were not always reviewed and kept up to date. The staff we spoke with told us that they were aware of the audits carried out by the manager and told us that the manager was quick to raise issues with them in order that they could improve their practice.

Staff did not always keep accurate or up to date records about the care they had provided to people. For example, the food and fluid charts we checked had not always been correctly completed and so did not reflect the correct amount of food and drink people had consumed. Records were stored securely and could be easily accessed.

There was a positive and open culture in the home and people felt comfortable and confident to speak up should they wish to. One person said, "I always say it's the best place to be." Another person commented, "It's a very happy place." The relatives we spoke with also felt the culture of the home was relaxed and open. During our visit the atmosphere was calm and people felt comfortable speaking with staff and the manager. We also observed staff communicating and working well together.

The staff we spoke with told us there was an open and transparent culture in the home and they were

comfortable raising concerns or saying if they had made a mistake. One staff member said, "I don't know the new manager very well but I would feel comfortable raising any issues." One staff member commented that there could at times be tension between different groups of staff, but felt that the manager was working hard to address this. There were staff meetings on a periodic basis and staff told us they felt comfortable contributing to these. Records showed that meetings were used for the manager to deliver clear and consistent messages about their expectations of staff. It was also an opportunity for staff to discuss any issues they wished to raise.

The service did not have a registered manager, however the manager referred to in this report had made the relevant application to become registered. In addition, another member of staff had also submitted an application to become a registered manager meaning that two people would share this responsibility. The people we spoke with commented positively on the leadership shown by the manager, whilst acknowledging they were very busy. One person said, "[The manager] is very strict and making changes for the better." A relative also commented positively by saying, "[The manager] is new and getting there. They will address problems and is very easy to talk with."

During our visit we observed that the manager made time to speak with people and staff. The manager also acted immediately on some of the feedback we provided to ensure immediate changes and improvements to the service provided to people. Staff told us that the manager and deputy manager gave them clear direction so they understood what needed to be done. One staff member said, "The manager is trying really hard to make this place better. They are quite supportive with me."

People benefitted from the clear decision making structures that were in place within the home. Staff understood their role and what they were accountable for. We saw that certain key tasks were assigned to designated groups of staff, such as ordering medicines. Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.