

Four Seasons 2000 Limited

Hemsworth Park

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



Overall summary

This inspection took place on 12 and 16 December 2014 and was unannounced. At the last inspection in December 2013 the home was not meeting legal requirements with regard to care and welfare of service users. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to ensure they were meeting the regulations. On this visit we checked and found improvements had been made.

Hemsworth Park Care Home is part of Four Seasons Health Care. It provides residential care for older adults, and those with dementia. The home also consists of a residential unit for adults, and a unit for younger people with disabilities. The home is registered to provide care for up to 93 people.

There was an acting manager in post; however this person was not registered. A registered manager is a

Summary of findings

person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

On the days of our visits we saw the majority of people looked well cared for. We saw staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

We found there were issues with regard to the managements of medicines within the home. This was in relation to the storage, administration and lack of guidance in place for staff to follow when administering 'as required' medicines to people. This breached Regulation 13 (Management of medicines) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We found areas of the home were not clean and equipment in place to assist people with their continence needs had not been attended to by staff. On the second day of our inspection we were told by the regional manager a 'deep clean' of the home would be carried out in response to this.

We saw areas of the home required updating. On the first day of our inspection new fire doors were being fitted to people's bedrooms on the residential unit. The regional manager told us there were plans in place for improvements to be carried out at the home.

Information and guidance within care records varied across the units within the home. For example, we saw that one person's care records on the nursing unit did not reflect their up to date mobility needs.

Staff we spoke with were aware of their responsibilities with regard to safeguarding people who lived at the home. They were able to tell us about the symptoms of possible abuse taking place and how they would report this.

People we spoke with told us they felt safe living at the home and felt they were well looked after. They told us they trusted the staff and felt the staff knew them well and how they liked support to be provided for them. We observed interactions between staff and people in the home and we saw staff appeared to know people well.

People told us the food at the home was good and that they had enough to eat and drink. We observed lunch being served to people on all four units within the home. We found there were differences in the way staff were deployed which impacted on the support people received.

People's privacy was respected. All rooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home. We saw that bedroom doors were always kept closed when people were being supported with personal care.

We saw the provider had a robust system in place for the purpose of assessing and monitoring the quality of the service. However, we found some of the audits in place had not been regularly completed or correctly with regard to medicines and daily management reports on the units.

We looked at four staff personnel files and saw the recruitment process in place ensured that staff were suitable and safe to work in the home. Staff we spoke with told us they received regular training and support. They told us they had annual appraisals by their line manager and regular training updates which ensured they had the skills they required for their role.

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the 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?

The service was not always safe. We found that appropriate arrangements were not in place to give medicines safely.

There were enough staff to keep people safe. Robust recruitment practices were followed to make sure staff employed were suitable and safe to work in the care home.

People were safe because the provider had systems in place to make sure they were protected from abuse and avoidable harm.

Due to repairs which were required some rooms did not have necessary equipment for people to summon staff for help. Some areas of the home were not clean.

Requires Improvement



Is the service effective?

The service was not always effective. People said the food was good but we saw closer monitoring of people's experience at mealtimes was required.

Staff were able to provide appropriate care to people because they were trained, supervised and appraised.

Staff understood how to support people who lacked capacity to make decisions.

Requires Improvement



Is the service caring?

The service was caring. However, we saw some people in the home who did not look well cared. For example, on one of the units two people's hair did not look clean. Another person's clothing did not look clean.

People we spoke with told us the staff were kind to them and they were able to talk to them. It was clear from our observations that the staff knew people well.

The staff we spoke with told us they felt they provided people with good care and that people were well looked after.

Good



Is the service responsive?

The service was not always responsive. For example, we saw the provision of activities within the home varied between the four units. Improvements were needed to make sure people of all abilities had the opportunity to take part in meaningful, social activities.

The home worked with professionals from outside the home to make sure they responded appropriately to people's changing needs.

Systems were in place to respond to concerns and complaints.

Requires Improvement



Summary of findings

Is the service well-led?

The service was not always well led. At the time of our visit there was no registered manager in post.

We saw the provider had a robust system in place for assessing and monitoring the quality of the service.

We saw evidence of audits and daily checks not being completed when delegated to care staff.

The provider worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Requires Improvement



Hemsworth Park

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 unannounced inspection was carried out on 12 December 2014 by three adult social care inspectors, a specialist pharmacist advisor and two expert's by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service. One of the adult social care inspectors returned to the home for a second day on 16 December 2014.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key

information about the service, what the service does well and the improvements they plan to make. We spoke with the local authority about the service and we also reviewed the information we held about the home.

At the last inspection carried out in December 2013 we had identified concerns regarding the care and welfare of people who lived at the home.

At the time of this inspection there were 67 people living at the home. During the inspection we spoke with 19 people who lived at the home, one visitor (a person's relative), 11 members of staff and the regional manager.

We spent time with people in the communal areas observing daily life including the care and support being delivered. We looked at five people's care records, 27 medication administration charts (MARS), four recruitment files and four staff training records, as well as records relating to the management of the service. We looked around the building and saw some people's bedrooms (with their permission), bathrooms and communal areas.

Is the service safe?

Our findings

We saw evidence which showed the provider had safeguarding policies and procedures in place. These were designed to protect people from harm. Staff told us they would raise any concerns they had with their unit manager immediately and were confident action would be taken. Staff were aware of the whistle blowing policy and knew they were able to take serious concerns to appropriate agencies outside of the home if they felt they were not being dealt with effectively. The acting manager confirmed there had been two safeguarding incidents in the last 12 months. We looked at records which showed these incidents had been reported to the appropriate agencies and where an investigation had taken place, records were in place to show the outcome and actions completed. This showed us staff were aware of the systems in place to protect people and raise concerns.

All of the people we spoke with told us they felt safe living at the home. One person told us “I like it here because you wouldn’t know it was a nursing home. It’s a home.” Another person told us “It’s a nice place to be.”

We looked at the recruitment records for four staff and saw evidence which showed recruitment practices were robust. Each staff member had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable groups. Each record showed detail of the person’s application, interview and references which had been sought. We spoke with two staff members who confirmed the recruitment process they had been through. This showed staff were being properly checked to make sure they were suitable and safe to work with vulnerable adults.

We found some areas of the home were not clean. In one of the bathrooms on the nursing unit we saw there were blood stains in the bath. There were also faeces left unflushed in the toilet. We returned later to check again and found it had not been cleaned. There was dried faeces on the lavatory seat in one of the shower rooms we looked in and faeces in the toilet. We saw toilet brushes for use were badly worn and/or stained. We saw pull cords for lights in toilets and bathrooms were badly stained. In one person’s room the bed had been stripped down but the soiled bedding was in a pile on the chair. The sun was

shining straight through the window and the door had been closed. The smell of urine in the room was overwhelming. When we looked around the dementia care unit we noted a strong odour of urine in some areas. This included the corridor as we entered and one bedroom. We noticed the commode in this unit contained urine and was not covered. The person was not in the bedroom. We saw one person’s bedroom door had faecal smearing on the door handle. We discussed our observations with the regional manager who told us they would take immediate action and ensure the home had a ‘deep clean’ carried out.

This breached Regulation 12 (Cleanliness and Infection control) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report

We looked at the way medicines were managed at the home. We saw medicines were not always given at their prescribed times. For example, on one of the units we saw medicines prescribed for administration at 8am were being given to people at 10am. We also saw medicines prescribed for 10am had still not been given at 11am. The NICE Guidelines on Medicine Management in Care Homes March 2014 also states that care homes should look at how long the morning medicine rounds take and discuss whether it may be safer to move the medicine administration of some ‘once a day’ medicines to alternative times so that the morning medicine round is not so long. We looked at records of ‘topical’ medicines which showed that occasionally this was applied either less often or more often than the prescriber intended. We found that barrier creams which needed to be applied in the morning on rising were recorded as being applied at lunchtime. Topical medicines are expected to be applied by staff trained to safely do so and who ensure the accurate recording of the application. We saw there was an anti-fungal topical medicine prescribed for a person on the nursing unit three times a day which had been recorded as being applied only twice a day. This meant some people were not receiving their prepared medication as prescribed.

We looked at the balances of MAR charts against current medicines and found there were discrepancies. For example, we saw eight people’s tablet or capsule form medication did not match their MAR charts on the nursing unit. We found there was more medicine in the trolley than the MAR chart showed, which may indicate that the

Is the service safe?

medicine had been signed for as administered but had not in fact been given. We observed medicines being administered to people at 2pm and we saw on both occasions the MAR chart was signed to show that the medicine had been given, before the medicine had been taken by the person. This practice on the nursing unit was judged to be flawed and therefore led to discrepancy.

We also saw other issues relating to the recording of medicines. For example, one person's medicine was not recorded on their MAR chart. All current medicines should appear on the MAR chart. Variable doses were not always recorded to show whether one or two had been given. In addition to the above some codes used on the MAR were of no value, for example it was observed that the 'F' code had no meaning. The MAR chart for one person had two entries for the same medicine, where a second entry had been written for a dose change. On two occasions both entries had been signed which meant that the person may have received more than the prescriber intended. We saw that the home were also recording daily that medicines were checked and correct on a separate audit sheet however, from the errors seen, the audit was not accurate. We saw there were gaps on new MAR charts and also evidence that gaps had been circled and signed for retrospectively.

We found non-medicated topical medicines which staff were required to apply were kept with the topical medication records in the bedrooms of people. We did not see evidence that this had been risk assessed for people living with dementia to ensure that it was safe to do so.

We looked at the recorded temperatures for all three fridges in the home and we saw that the minimum and maximum recorded temperatures had been the same for long periods. This indicated that the internal memory for the fridge thermometer had not been reset after each recording. This meant the records completed by staff did not show the accurate temperature of the fridge, nor could they ensure medicines were being stored at the correct temperature.

This breached Regulation 13 (Management of medicines) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We looked at accident and incident records and saw these were analysed on a monthly basis by the manager. This meant that any themes or trends could be identified and action taken to minimise the risk of reoccurrence.

We saw the staffing levels in place at the home ensured there were enough staff on duty to meet the needs of the people living there. We received positive feedback from staff on duty regarding this. One staff member told us "We have enough staff to get done what needs to be done. We also have the activity staff to make sure people have got something to look forward to. I know that staff are always working in a way which means people have the best quality of life possible, we really do our best."

We saw safety records and maintenance certificates, such as gas safety, legionella and portable appliance tests (PAT) were up-to-date. There was a detailed fire evacuation policy and we saw fire safety checks were recorded monthly and were up-to-date. However, there were some areas of the home which required updating and redecoration. For example, in one person's bedroom we saw there were cracks in the plasterwork on one of the walls. We reported this to the regional manager who took immediate action and asked the person if they wanted to move out of the room whilst repairs were carried out. We also saw a number of doors throughout the home had broken handles which did not work properly. These issues had also been reported for repair. We also found issues with equipment which enabled people to summon help. For example, call bells did not reach to the floor in some of the bathrooms and toilets on the dementia care unit. This meant that if someone had fallen they would not be able to reach the call bell to get help. We recommend that a full audit of the premises is undertaken to ensure it meets the specialist needs of all the people who live at the home.

Is the service effective?

Our findings

Staff we spoke with told us they received the training and support they required to carry out their roles. They said they received regular supervision sessions and appraisals and we saw evidence of this in the staff records we looked at. Staff were able to describe clearly the needs of the people they supported and knew how these needs should be met. The training matrix showed the training staff had completed as well as the training they required for their role such as health and safety, information governance, first aid, dementia, infection control, fire safety, deprivation of liberty, food hygiene, medication awareness, safeguarding and moving and handling. We also saw updates for training were booked as soon as training was completed. The current percentage of staff that had completed the required training was 98% at the time of our visit. We spoke with staff about the training they received and how it had enabled them to provide necessary care to people. One staff member told us they had received dementia training the week before the inspection and this was really good. They discussed what good care looked like and what bad care looked like and when giving someone a cup of tea, how to do it with kindness and choice and offering people a choice of milk and sugar. Staff also discussed how to put clothes away for people with dementia. This demonstrated that the training was aimed at raising staff awareness of how to treat individuals with dignity and respect and promote individual choice for residents.

We spoke with two staff members about the induction they received before they started work at the home. They said it had been very useful and felt it had prepared them well for their role. They told us their induction had consisted of completing mandatory training, spending time shadowing more experienced staff and also looking through people's care records. They also said this had given them the opportunity to get to know what people's needs were and how to support them best. One member of staff indicated that some of their training was via e-learning (via the internet) though they preferred practical sessions. They told us their unit manager had followed up some of these e-learning sessions with a practical session.

The acting manager and staff had a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty (DoLS). The training records showed staff had

received training in MCA and DoLS. The acting manager was fully aware of the latest judgement issued by the Supreme Court in March 2014 in respect of DoLS. This judgement widened and clarified the definition of deprivation of liberty and therefore had implications for all adult health and social care providers. There were no DoLS in place at the time of our inspection however; one application had been made in November 2014. We looked at five people's care records and saw that four of them contained evidence which showed they had consented to the care and treatment they were receiving. The consent documents in the other care record we looked at were blank. We spoke with the acting manager about this and they told us they would speak to the unit manager to take action on this.

We saw a reminiscence room had been developed on the unit for people living with dementia. This provided people with a comfortable and homely place to spend time recalling period furnishings and objects from the past. The corridor of the unit was well planned and offered people varied things to look at, touch and rummage through. There was seating in the corridor to enable people walking with purpose to rest and memory boxes outside every room. This meant people living with dementia had access to appropriate facilities.

Staff we spoke with told us people were supported with accessing health care services such as GPs, dentists and opticians. The four care records we looked at confirmed this. This showed people living at the home received additional support when required for meeting their care and treatment needs.

People had sufficient amounts to eat and drink. However, when we observed lunch being served to people at the home we found the experience of people on some of the units was not as positive as on other units. We observed that staff were not available to provide the level of assistance required by some of the people living at the home. For example, on one unit we saw staff offering people choice about where they would like to sit for lunch, some chose to stay in the lounge. Staff gave people choices of food and drinks. Two people who requested alcoholic drinks were provided with these. We also saw people appearing to enjoy the company of staff who they chatted with as they were served their meal on the upstairs residential unit. However, during lunch time on another unit we there were six people in the dining room with only

Is the service effective?

one staff member. We saw one person required a staff presence as they attempted to grab a hot plate. The member of staff in the dining room saw this and stopped the person from grabbing it. We observed that people were largely unattended, particularly two people who required assistance with eating. One person with severe physical difficulties was left for quite a while because there was no other staff member present. We observed that one or two people eating their meals were watching out for the others and encouraging them to eat. One person left their entire meal and got up to leave the dining room. The member of staff said, "Aren't you very hungry?" We did not hear the person being offered anything else. Another person had fallen asleep at the table and was left unattended. This was because the staff member was assisting another person

who needed one to one support. When we asked the staff member about this we were told, "Oh, they can eat without help sometimes." During lunch time on the nursing unit we saw two people who were having their food via a PEG. We saw there were no staff sitting with them whilst they had their food, and they were isolated and unstimulated. We spoke with the acting manager and the regional manager who told us they would address the issues raised immediately by looking at staff deployment over mealtimes. On the second day of our inspection we were told staff were now available to support people who were not eating during meal times. The acting manager told us they had also spoken to staff regarding their availability to support people in the dining rooms.

Is the service caring?

Our findings

The home had named the unit where people with dementia were living “The Dementia Unit” and this name was used in written communication such as the activity plan for the month. Through conversation with people living at the home we found that many communal activities took place in the lounge on the unit and where this was the case the location was described on the plan as “The Dementia Unit”. This means that in some ways the people living on that unit were defined mainly by their condition which compromises attempts to provide a caring experience.

As part of this inspection we intended to conduct a SOFI (Short Observational Framework for Inspection) on the unit for people living with dementia. SOFI is a way of observing care to help us to understand the experience of people who could not talk to us. However, we found that all the people we were observing were able to speak with us. We also saw that all of the people we had intended to observe were engaged in various activities throughout the day during which they showed signs of enjoyment, engagement and wellbeing. We observed staff interactions with people to be positive, respectful and caring, particularly on the dementia care unit. Staff engaged with people easily and clearly knew them well.

People told us that they felt the staff treated them with kindness and compassion. We observed persons frequently asked staff where they were and what were they doing there. On each occasion staff members discreetly and caringly gave the person the information they were asking for and checked that they understood. The person looked reassured each time, and the response they received was consistent in its quality even when the same member of staff was being asked. Once reassured we saw the person looked happy and re-engaged in talking to other people.

We spoke with a staff member on the residential unit who told us they were very happy working there and that the residents love them. They told us they come in when they are on leave to watch DVDs with them as they have cried when they were told the staff member was on leave.

On the nursing unit we observed a person shouting out. Staff told us that this person did this when they were uncomfortable and wanted to lie on their bed. A nurse came and took the person, from their special chair, to their

room. However, after 20 minutes we could still hear the person shouting. We went to their room and saw they were still in their chair. When we asked a member of staff if the person was going to be assisted to bed they said “He does that all the time, we were busy.”

We saw there was a programme of activities in place at the home and two people were employed specifically for the purpose of planning and facilitating activities. We saw the activity taking place at the time of our inspection was baking. We saw that a large number of people had chosen to be involved. We spoke to other people in the home who did not wish to take part in the activity. They told us that although they did not wish to take part in the baking activity there was nothing else for them to do. One person told us “Nobody bothers with me. When I first came here they used to come in and see me but now they don't bother at all. I do get taken to the pub three times a week. I have to go out for company. I've never been told about any trips (outings). I call it Colditz. I feel like I'm in prison.” We asked a number of people what they thought about the activities on offer to them at the home. One person told us they did not do anything. They said “It's like every other day. We sit and do nowt.” We spoke with the acting manager and the regional manager about this and they told us they would speak to the activity staff about these issues. On the second day of our inspection the regional manager reported they had spoken with one person about increasing their time out of the home. The person had said they were happy with their visits to the pub.

We spent time observing care on the upstairs residential unit of the home. We saw the unit manager was present and providing care for people in addition to two members of care staff. We found the interactions with people were very warm and caring and displayed the good depth of knowledge the staff had about people. For example, we saw one member of care staff had a warm drink waiting for two people who came back from participating in an activity. One person told us “She knows how to look after me.” Another person had mentioned they felt a bit chilly. The same staff member went and fetched a warm cardigan for the person. They told us “They are so good on here you know, nothing is too much trouble.” We observed one person who had very limited communication was supported at lunchtime by a member of staff who was very kind and patient with the person. They sat with the person

Is the service caring?

and talked them through what they were having for lunch asking if they wanted anything else and if they had enjoyed it. This showed people were supported and cared for by people who knew them well.

Is the service responsive?

Our findings

We looked at the way the home managed concerns and complaints. We saw there was an up to date complaints policy in place. We saw copies of the complaints procedure was also displayed in the home. The complaints procedure included contact details for the senior managers in the organisation, the Local Authority, CQC and the Ombudsman. The regional manager showed us the complaints log which showed five concerns/complaints had been received in 2014. The manager had dealt with the concerns raised using the complaints procedure and we saw evidence which showed all complaints but one had been dealt with to the satisfaction of the complainant. People we spoke with told us they knew how to make a complaint and who to go to if they had any concerns. This meant there was an effective complaints procedure in place.

We spoke to two members of staff about whistleblowing and asked them whether they felt able to raise concerns. Both staff members spoke highly of their unit managers and felt that they could go to these individuals with their concerns and that they would act on them. Another staff member we spoke to advised us that if they saw any break in the criminal law, health or safety or care of a resident; they would report any incident to the Head Office and if they had no response would go to Care Quality Commission. Staff told us they were aware of the policies in place regarding whistleblowing.

We reviewed the care records of five people living at the home. On the upstairs residential unit we found one person's records included the very recent actions identified at a recent safeguarding meeting concerning their care. This showed the home had updated the person's records in a timely manner. We looked at the assessments which had been carried out for the person and saw they contained information regarding their health and wellbeing, mobility, skin integrity, falls, nutrition, communication, psychological and emotional needs. From this we saw care plans had been developed which provided staff with clear guidance on how to meet the person's needs. Daily records completed at each shift showed how support was given in accordance with the care plans. Monthly reviews were detailed and monitored the person's progress. We looked at care records for a person with complex care needs on the nursing unit. We saw that a number of referrals to

community based healthcare professionals had been made in order to support staff in meeting the person's needs. We saw that when a visiting professional had been to see the person, their advice was recorded within the care records. On the dementia unit we found that a person who had been living at the home for three months still had a 'New Admission Booklet' in place. The booklet contained evidence which showed assessments of the person's need had not been carried out. We spoke with the acting manager and the regional manager about this and when we returned on our second day of inspection they told us they had taken action and the person now had a care plan in place for staff to follow.

On the nursing unit we found the care plans of two people were very difficult to follow and did not enable us to gain an understanding of the care needs of each person. Each section had a daily and a monthly update, but these were not completed daily so it was difficult to get an accurate picture of how to care for the person. For example, in one care record we saw a document titled 'assessment/reassessment' had not been signed or dated by the person completing the assessment. We saw in the 'mobility' section it stated the person can mobilise with the assistance of two carers and equipment required was a 'Zimmer frame'. However, later in the mobility section dated 15 May 2014 it stated the person was not able to weight bear and needed to be hoisted. This meant the person was at risk of receiving inappropriate and unsafe care. We asked the Nurse in Charge to go through the case record with us because it was so difficult to follow, and they agreed with this opinion as the information contained was confusing.

We discussed the case records with the Regional Manager who told us the provider was aware of the issue and had been piloting a new system which hopefully would be put in place in January 2015. They also said staff from other units had been involved in designing these. We were advised that the provider have received the same criticism of the care records from staff, commissioners and other regulators. The Regional Manager and Unit manager told us they had met the day before the inspection to discuss the care records and an immediate action was to remove historical information from files to reduce the risk of unsafe care provided to people. These actions demonstrated that the provider has listened to concerns and had acted on them. This also showed that the Regional Manager, who

Is the service responsive?

had been in post for three weeks, was providing leadership and was proactive in trying to improve the care of people by improving the care records in advance of a new care record system.

People we spoke with did not express any concerns about getting support and care whenever it was needed. One person told us “They spot when I might be feeling a bit down and they come and talk to me, give me a lift.” People also told us they felt they had freedom to decide when they got up and went to bed and could maintain their own routines in this respect. One person told us “If I get up a bit late I can still get breakfast – that’s not a problem.” People also told us they felt that they could bathe or have showers

whenever they wished. One person told us “They (staff) come and help me - I say when I want a shower. I like the way they do it.” People told us that they found it easy to maintain friendships and receive visitors whenever they wanted. One person told us “I can use the phone in the office; my relatives can come whenever they want and I can go out with my relatives when they come.” Some people told us about opportunities to go out, citing occasional trips for social activities or shopping. One person told us “I can only go out when there’s a member of staff with me. I don’t know why.” This showed that people were supported to maintain relationships.

Is the service well-led?

Our findings

At the time of our inspection the home did not have a registered manager in post. We were told that a new manager had been recruited and would start work at the home in January 2015. There was an acting manager in post who was being supported by the regional manager. We were concerned that the acting manager also had to take charge of a unit due to staff sickness. The person told us they only had two days during the week of our visit when they were not in charge of a unit and therefore able to do managerial duties. We found the regional manager to be interested in all of the feedback we gave and was open and transparent about the management problems in the home at that time.

We spoke with 11 members of staff about the management and leadership at the home. We received positive feedback regarding the unit managers in place at the home. Six staff members told us they felt their unit managers were very approachable and they felt their unit was well led. One of them told us “I can go to them with anything, they listen to me and that’s important.” Another staff member told us “We can discuss any issues we have with our unit manager and they will sort it out. There’s no problem with saying it how it is.” Two other members of staff told us they felt the presence of the regional manager had made a difference at the home. They told us “She’s interested in how we see things. She wants the best for the people living here and so do we so that makes things easier.” They also said “I’ve never had a problem with going to her if I had to, she’s very approachable.” Staff we spoke with told us they had recently had meetings where all staff were invited to attend to discuss the changes and culture at the home. They said they found the meetings positive and saw it as a chance to change some of the negativity there had been at the home in the past. They told us “It’s nice to know we can all move on and get on with just getting the job done. I enjoy my job and I know other people really like working here.” This showed there was an open culture at the home where staff felt able to challenge directly.

We saw there was a system in place of audits which were designed to monitor various aspects of the service. Where issues were identified we saw action plans had been put in

place with timescales for when actions needed to be completed. We saw there were daily checks in place on all of the four units which were carried out by staff or the unit manager. These were to ensure standards were maintained with respect to medication, environment, documentation, calls bells and completion of handover documents. However, we found that some of the documents had not been completed and contained gaps. There were also missing signatures of unit managers. This meant the checks in place were not being carried out and therefore standards may not be maintained. We spoke with the acting manager and the regional manager who told us they would address this with the staff concerned.

We spoke with the regional manager about how they gathered the views and opinions of people living at the home. We were told that ‘residents meetings’ took place on a monthly basis. We looked at the minutes of meetings held in August and October 2014. We saw evidence that where people had raised issues the home had responded. For example, people had asked if there could be arrangements made to have newspapers delivered to the home on a daily basis. We saw this had been actioned immediately. We spoke with people who lived at the home regarding whether they had opportunities to give feedback to the management of the home. Awareness of meetings or surveys was not evident amongst people living on the dementia unit, although several people told us that they would deal with any concerns directly and informally. One person told us “If I wanted to tell them something about the way things were done then I would. I’d just go and talk to them.” On the nursing unit people were more able to tell us about meetings held in the home, and confirmed that they were attended by people from all units of the home. One resident told us “There are meetings every month, I think. They understand how we feel and listen.” Another person told us “They have the decency to listen to us. We have started getting newspapers every day again and that’s because we brought it up at a residents’ meeting.” We did not see any posters or other means of advertising the meetings and there did not appear to be any minutes freely available, however it was clear that these did happen and people could give us examples of something that had changed as a result, meaning that the meetings had some value for the people living at the home.

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 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	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control
Treatment of disease, disorder or injury	People were not cared for in a clean, hygienic environment. Regulation 12 (1)(2)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines
Treatment of disease, disorder or injury	People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13