Crossley House

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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

Overall summary This inspection took place on 30 November and 1 December 2014. The inspection was unannounced. The previous inspection was carried out 22 May 2013 and there had been no breaches of legal requirements at that time.

Crossley House is registered to provide accommodation for up to a maximum of 17 people. The service cares for older people, some of whom are living with dementia. At the time of our inspection there were 16 people living in the care home.

A registered manager was not in post at the time of inspection. 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 and associated Regulations about how the service is run. The home did have a registered manager in post.

Summary of findings

People in the home were not always safe. We found errors in the recording and auditing of medicines. This was around the maintaining of stock levels, administration of medicines and lack of effective auditing process.

One person did not attend a medical appointment that should have taken place. The manager or staff had not noticed the appointment hadn't taken place. This person was placed at risk of not receiving safe care.

Staffing levels were not always sufficient to meet the current needs of people living in the home. The majority of staff and some relatives told us that staffing levels were insufficient at peak times, especially during the evening.

Some people's risk assessments lacked detailed guidance for staff to follow as they were not always comprehensively completed. This meant that staff did not have full information to ensure people were kept safe and protected from harm

Not all records were completed fully. Some people's care files lacked recordings in relation to their care and treatment. This included nutritional recording charts. This posed a risk to people's individual needs not being met effectively.

People were not always protected from the risks associated with Infection Control. The home did not follow the Department of Health infection control guidelines or similar guidance. Areas of the home were cluttered and the laundry and kitchen were not clean. Some staff did not use the correct procedures when handling used laundry.

Some people had not received food hygiene training and were involved in the meal preparation. Therefore people could be at risk of food borne illnesses.

People were happy with the food and drink they received in the home. However we observed a mealtime where some people's needs were not being met effectively. We found that some people did not receive the support they required.

The provider had not ensured that staff had the knowledge and skills they needed to carry out their roles effectively to ensure people who used the service were safe. Some staff had not completed their safeguarding adults training to ensure their knowledge was current and in accordance with current guidance.

Staff had training and awareness of the Mental Capacity Act 2005. Documentation confirmed correct processes had been followed. Staff that we spoke with had a good understanding of the processes that needed to be followed.

There were positive and caring relationships between staff and people at the service. People praised the staff and told us they provided a good standard of care even when they were very busy. We observed people to be relaxed in the company of staff and engaged in conversations.

We received some positive feedback from relatives and visitors while they also acknowledged staffing levels appeared not always to be sufficient.

Some people's care records demonstrated their involvement in care planning and decision making processes. Some people had signed their documentation. This was confirmed when we spoke with people living in the home and their relatives.

People received regular reviews of their care needs; however we did find the service had failed to ensure some people's risk assessments were fully reflective of their current needs. We have made a recommendation that the provider reviews peoples risk assessments and ensure they are cross referenced against each element of their care plans.

Staff meetings and manager meetings were scheduled regularly and staff were encouraged to express their views. Meetings were held with people and their relatives to ensure that they could express their views and opinions about the service they received. People could also raise any complaints at these meetings.

Quality and safety in the home was monitored to support the manager in identifying any issues of concern. However they were not robust and had not identified all the shortfalls found during this inspection. This included medicines and infection control.

We found breaches of six regulations relating to medicines, staffing, care of people in the home, records, infection control and quality assurance systems. 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?

Requires Improvement

The service was not safe

Infection control policies and procedures were not always followed by staff. Some areas of the home were dirty.

Systems related to the administration of medicines were not robust. Some people's 'as and when required' medicines were not recorded and administered correctly. Medicines audits were not undertaken.

Staffing levels at peak times were not sufficient to meet the needs of people safely.

Not all people's risk assessments were reflective of their current needs.

Is the service effective?

Requires Improvement

The service was not always effective

Nutritional records were not always accurately completed to allow staff to monitor people's care to ensure their needs were met.

Handover records were inconsistently completed and lacked detailed information for staff to follow.

Some people's change in health needs were not acted upon. Referrals to external professionals were not always made promptly.

Not all people were supported at mealtimes in a way that met their needs. We recommend that the provider reviews the way the mealtime experience is conducted.

Issues relating to people's mental capacity were considered in their care plans and people and their relatives were involved in their care planning.

We saw processes were in place to detect any decline in health.

Is the service caring?

Good

The service was caring

People and their relatives told us the staff were genuinely caring and were sensitive to their needs.

We observed staff caring for people in a respectful and compassionate manner.

We found people's opinions were sought through surveys and resident meetings.

Is the service responsive?

Requires Improvement

The service was not responsive

Summary of findings

Some care plans were not were representative of people's current needs as they held contradictory statements.

A person's long term health condition was not managed in line with their assessed need. They did not receive their follow up blood test in line with their needs.

The provider had a complaints procedure and people told us they felt able to complain.

People were supported to maintain their independence and social activities were available.

Visitors were made welcome in the home and were involved in activities that took place.

Is the service well-led?

Requires Improvement

The service was not well-led.

There were quality assurance systems in place however these were not robust and failed to identify shortfalls in the service.

Some staff told us they felt unsupported by the management team.

The provider encouraged people and staff to express their views and opinions.

Staff meetings and manager meetings took place. Staff were given opportunities to discuss the care provision.

Crossley House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 November 2014 and 1 December 2014 and was unannounced. The inspection was undertaken by two 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.

The inspection took place in response to information of concern that we had received about staffing levels and the impact this had on the care and welfare of people living in the home. We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us. We also reviewed 'share your knowledge' forms that we received from people with experience of the service which also raised similar concerns. Our inspection included attending the home on a weekend evening. This was to gain a full overview of the service on the weekend and different times of the day.

During our inspection we spoke with nine people who used the service and six relatives. We spoke with eight members of staff, the provider, the training and quality assurance manager and the manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records and supplementary records of three people who used the service and reviewed documents in relation to the quality and safety of the service, staff training and supervision.

Requires Improvement

Is the service safe?

Our findings

The staffing levels were not always sufficient to safely meet the needs of people living in the home. Prior to this inspection we received information of concern in relation to insufficient staffing numbers and the impact on people living in the home. People living in the home that we spoke with had a form of dementia. They were unable to tell us if they felt the staffing levels were sufficient. Therefore we spoke with their relatives and the staff during our inspection.

Feedback from the majority of staff confirmed that there were times when more staff were required. For example between the hours of 5:30pm to 7:30pm. This was a time when only two care staff and a member of staff in the kitchen were on duty to meet all the needs of people living in the home and support bedtime routines. Some people required two staff to support them with their personal care routines. Therefore there were periods of time when people would be left unattended and without support. Information of concern that we recently received also detailed times when people were left unattended in the communal areas and there were concerns about people's safety. This was observed during our inspection for example, people were observed alone in the communal lounge for periods of time up to fifteen minutes. This could pose a risk to people's safety as not all people could independently mobilise.

Staff we spoke with also told us they felt more staff were needed at peak times. Comments included: "we definitely need more staff. Since CQC have been in we have an extra carer and this has helped". "Some residents need two carers and it can take 20 to 25 minutes with one person. We need an extra carer from tea time." We discussed the comments with the manager who confirmed one person would require the support of two members of staff due to changes in their needs. This meant at peak times people could be left without adequate support.

One of the care staff was also required to undertake a medicines administration round during the evening when only two members of care staff were on duty. This removed one member of staff from supporting people's care routines. This posed a risk that people would not receive care and support when they needed it and a safety risk to the medicines round being interrupted, which could be unsafe.

Some relatives confirmed they were concerned about the staffing levels and the large staff turnover. One relative told us "Everything was very stable for the first year but now there is a complete change of staff. It is upsetting and off-putting for us, so we worry about what it must be like for the residents, not having continuity of care".

Due to the risks identified during our inspection we asked the provider to consider increasing the staffing level in the evening when only two care staff were on duty. The provider took immediate action and increased the staffing level following our inspection.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Staff who administered medicines were given training and medicines were given to people safely. On the second day of our inspection we observed some medicines being administered. We saw one person was given eye drops and ear drops before they started their meal. The MAR chart was updated immediately. We saw one person declined their medicines. This medicine was safely stored ready to return to the pharmacy and the MAR sheet was properly completed.

However recording, auditing and storage systems relating to medicines were not safe. A

medicines policy was in place that set out how medicines should be managed by staff. The policy was guidance for staff to follow to safely manage people's medicines. The policy guidance included: staff training, administration and auditing of medications. However this was not always followed.

Medication Administration Records (MAR) showed there were systems in place to record administration of medicines appropriately. However we found some entries were not clear or in line with the prescribed medicine. Some daily entries were not signed for making it difficult to check if it had actually been given. Stock numbers of medicines did not match what were held in the home. No stock checks were undertaken to ensure that medicines could be accounted for. This meant that staff could not easily check whether people had received their medicines as prescribed.

Some recordings lacked clarity; one person's prescribed medicines stated 'one or two tablets to be taken daily'. However the MAR did not record the amount that was

actually given so that this could be monitored. Another person's medicine stated 'take two tablets at night'. However, the MAR chart recordings showed this medicine was being given at different times. Therefore some medicines were not being given as prescribed by the GP as the MAR chart and instructions on the box did not match.

We checked the contents of eight boxed medicines with a senior member of staff. These were medicines to be administered 'as required'. We found all the medicines stock levels were not correct so had not been monitored effectively.

Storage of people's medicines was not always safe. The medicines trolley was disorganised and some strips of people's 'as required' medicines were found to be loose within the trolley. This posed a risk of people being given other people's medicines. A carrier bag was found in the trolley and it contained a large number of medicines. Some had also fallen out of their boxes We asked the manager and a member of staff why the medicines were stored in this way. They told us this person was on a short stay in the home and this was how they were brought in two weeks previously. This presented a risk that people may be given the wrong medicines.

The manager told us they regularly looked at the MAR sheets to look for any gaps and then spoke with the member of staff on duty to check if they had been given. However we found gaps that were related to the 27 November 2014. We were told by the manager they were introducing an auditing process into the home to pick up errors quickly.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We saw that there were policies and procedures in place to support staff in maintaining a clean environment. However we found that Infection control guidelines had not always been followed. Not all areas of the home were clean and free of clutter.

We viewed the kitchen area with the provider and the manager. The kitchen area was small and was dirty and cluttered. Stainless steel work surfaces were dirty and cluttered with crockery and equipment making these areas difficult to effectively clean to reduce the risk of food contamination.

A maintenance person was seen undertaking a deep clean of an extractor hood. Food was in close proximity and covered only by net type covers. There was a risk of this food being contaminated by dirt from the cleaning.

Coloured coded chopping boards were in place. However they were badly scored and debris and fluff was found within the scores. This posed a risk as the boards could not be effectively cleaned and dirt and germs be transferred during food preparation.

The kitchen floor was dirty and cluttered with plastic storage trays and a standing stool that was ingrained with dirt and grime. The large waste bin was standing against a cupboard. It would have to be moved around the kitchen so staff could reach other areas, as there was no designated place for it to be stored. Therefore there was a risk of cross infection as staff would be moving the bin regularly with their clean hands and in between food preparation tasks.

We observed a plastic box on the side of the sink that held used dishcloths, gloves and sponges. This container had two inches of dirty water lying in the bottom and the gloves and sponges were filthy in appearance. We observed these being used to wash the crockery earlier that day. This posed a risk of cross contamination. The manager immediately removed this.

Kitchen cupboards were broken and damaged and a freezer was dented and had enamel missing. These could not be effectively cleaned. The provider told us the kitchen area was under refurbishment and some works had been completed. The provider agreed with our findings.

Not all staff received statutory food hygiene training. We discussed this with the manager who confirmed some staff who need to be in the kitchen to cook the meals, had not received the necessary training and should be trained in this area. Training records confirmed this. The manager was arranging for all staff to complete this as soon as possible.

The small laundry room was dirty and cluttered. For example, two mops and buckets were in front of the door. An incontinence waste product bag was on the floor unsealed. Boxes of detergent were taking up a large amount of the already small floor space. Therefore this area could not be effectively cleaned to reduce the risk of cross infection and the lack of available floor space could be a health and safety hazard as staff had little space to manoeuvre.

Requires Improvement

Is the service safe?

In the upstairs bathroom the toilet was badly stained and scratched making effective cleaning difficult. A toilet brush was dirty with faeces. A bath had missing enamel, was badly scratched and there was a mouldy bathmat in place. Cleaning of these areas was ineffective.

The provider's policy was not followed in relation to laundry facilities. Items of dirty clothing and linen were placed on top the washing machine without using the recommended colour coded laundry bags. Clean laundry was viewed on top of the tumble dryer and another basket was on the floor, resulting in clean and dirty laundry being placed in close proximity. Dirty tea towels were viewed soaking in the sink. Therefore making it difficult for staff to have immediate access to the sink.

Personal protective equipment (PPE) was available for staff to use when undertaking personal care or domestic routines to reduce the risk of cross infection. However these were not always used. We saw two members of staff carrying dirty washing around the home in their arms without using the appropriate laundry bags. They were holding the washing against their own clothing without using a plastic apron. Therefore the Department of Health's publication: The Code of Practice for health and adult social care on the prevention and control of infections and related guidance was not always followed.

We discussed our findings with the manager who informed us staff undertook training in this area and staff were aware of what they should do. Staff confirmed this when we spoke with them. When we returned on the second day of our inspection the manager had taken action to clear and clean the laundry area and de clutter a quiet lounge that was also used as office space.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and the manager told us no member of staff would start working in the home before all relevant checks were undertaken. This was confirmed by staff who were new to the service.

Risks to people's safety were assessed before they came into the service. Risk assessments for falls, manual handling and other health care needs were carried out. However some needed more specific guidance for staff to follow. For example, a bathing risk assessment for one person did not identify the number of staff needed to assist a person. While another person's manual handling risk assessment when cross referenced with their falls risk assessment, did not match. For example, one stated one member of staff to support and the other stated two at all times. Therefore this was inaccurate information and posed a risk of people not being supported safely, as staff did not have the correct guidance to support them.

The provider had a system in place for recording and reviewing incidents and accidents. Information was recorded and reviewed by the manager and audited monthly. The system allowed any trends in the kind of accidents occurring to be highlighted, so that appropriate actions could be taken to address them. The monthly audit was recorded in the form of a clock face to highlight any particular trends at a certain times of day. This identified if any greater risks were posed for people at different times of the day.

Equipment used within the home was maintained to ensure it was safe to use. The provider had a programme for maintenance which included the fire alarm and electrical systems. During the second day of our inspection we viewed a yearly electrical systems check taking place. Therefore equipment and electrical systems used within the home were maintained to ensure it was safe to use.

The provider had arrangements to respond to suspected abuse. A clear policy was in place for people to follow and staff demonstrated an understanding of who they would report to and staff received training. All staff told us they would have no hesitation in reporting any concerns should the need arise. However not all staff were up to date with their safeguarding training. The manager told us this would be arranged in the near future for the staff that failed to attend the previous dates.

We asked staff if they understood the term 'whistle blowing'. This is a process for staff to raise concerns about potential malpractice in the workplace. Staff understood whistleblowing and the provider had a policy in place to support people who wished to raise concerns in this way.

Requires Improvement

Is the service safe?

We recommend that the provider reviews people's risk assessments to ensure they are reflective of their current needs.

We recommend that the provider reviews staff training records to ensure staff receive refresher training promptly.

Requires Improvement

Is the service effective?

Our findings

People's records were not maintained accurately and completely to ensure full information was available. We saw three care plans. For example, the' at a glance section' plan provided only basic information. This was not dated and therefore staff would not know if this information was current and still reflective of people's needs.

We saw two different styles of food and fluid charts were being used. These are charts that staff use to record what people who are at risk of malnutrition or dehydration eat and drink throughout the day. Many were not fully completed. For example, on 23 November 2014 one person had nothing recorded on their chart until 3pm. This lack of consistent recording continued for several days. Other people had two (duplicate) recording charts that could lead to confusion as it would be difficult to total the amount of fluid the person had. Some of the forms were either duplicated or had no dates on them. We asked staff and the manager about the lack of recording and they stated people would have received food and drink in line with their assessed needs, but confirmed staff did not always remember to record the detail. The lack of effective recording could pose a risk of people's nutritional needs not being monitored effectively.

We were told that handover sheets were used to effectively hand over important information between shift changes. However the handover sheets were not consistently completed and there were several occasions where the dates were either not recorded or incorrectly recorded. This meant the handover sheets were ineffective and did not give staff the information they needed to be able to provide appropriate care for people as they were not consistently completed fully.

Some people's care plans were not reflective of their needs and held contradictory statements. For example, how often people needed to be checked at night. One person's care plan said the person needed to be checked hourly in the night care plan, but a different entry said they needed two hourly checks. If care plans are not fully reflective of people's needs there is a risk of unsafe care being provided

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

All staff we spoke with told us they had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training (DoLS). This is legislation to protect people who may not be able to make certain decisions for themselves. Staff were able to tell us why this legislation was important. We saw information in people's care plans about mental capacity assessments and standard applications to the local authority for deprivation of liberty authorisation. The forms used were appropriately recorded. The MCA 2005 provides safeguards for people who may not be able to consent to care. This meant the registered manager was aware of the process involved and how to make the necessary applications.

Consent to care and treatment was recorded within people's care records and documentation gave details of who was involved in their care and treatment planning and signed wherever possible. During our observations we heard staff asking for people's consent to undertake their care routines. For example one member of staff said "would you like to have a bath [name]". A member of staff told us "I always ask if they would like a bath as they may have changed their mind".

We saw processes were in place to detect any decline in health. Nutritional risk assessments were in place and people were weighed regularly. A nationally recognised tool for monitoring people who were at risk of malnutrition was used.

Not all people were able to tell us their experience of the food that was offered due to their level of dementia. However, those people who were able and their visitors were complimentary about the food, saying: "Good food" "All fresh veg, I always eat what they give me". "Food has always been excellent". "My relative enjoys the food; they are a slow eater and are still eating their main course when all others are finished and rather than leave them alone in the dining room they serve their dessert in their room where they can eat at their own pace".

We were told a three week rolling menu was in place and all food was home cooked that included making their own cakes and bread. Staff told us ways in which people were given choices of food. One staff said "We have a menu and ask people what they want the day before." However on the day of our inspection the lunchtime menu was changed from what people had chosen. We were told this was due to a delivery problem. Therefore people were offered

alternatives. Staff told us picture menus were being planned to be used in the future to give greater choice to people who may not be able to make their choices known verbally.

During our observations of the mealtime, the atmosphere in the dining room was rushed; and staff appeared to serve and clear away dishes as quickly as possible. We observed little interaction between staff and residents; people were just asked "have you finished?" and were not necessarily encouraged to eat any more or offered physical support. When dessert was served, it was placed in front of the person without them being told what it was or being asked if they wanted cream.

One person picked up a fork, which was closest to them to eat their dessert and commented that it 'had holes in it'. They proceeded to eat with difficulty spilling food onto their sweatshirt. There was a spoon by their right hand but they were not aware of this. A member of staff who was in the room failed to notice this, neither did they notice another resident who was eating their meal while they had a dripping nose. None of the people had suitable protection to use during the meal, resulting in several people soiling their clothes. Not all people were supported at mealtimes in a personalised way to effectively meet their individual nutritional support needs.

All the records showed staff had not received regular one to one supervision. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. This was confirmed by the manager who told us they had only been in post a few months and intended to set a supervision plan in place. However one member of staff told us they would approach the management if they needed one to one supervision time and would not wait for a session to be arranged.

Staff received appropriate training to carry out their roles. However training records demonstrated that not all staff had received training or their updates. This included; infection control, safeguarding, dementia awareness and manual handling. However when we spoke with some staff who had received the training they felt training was sufficient in order for them to perform their role.

We recommend that the provider reviews mealtimes and takes account of best practice to ensure that people's needs are met.

Good

Is the service caring?

Our findings

People told us the staff were genuinely caring and were sensitive to their needs. Comments included: "They look after me well here; female carers are good - male ok". "They treat me well and are generally ok- no cause for complaint". "Staff are kind, I sometimes get incontinent; they just sort it and say 'Don't worry'". Another person said "Everything is wonderful; I would tell staff if it wasn't; I can talk to any of them".

Relatives told us they were happy overall. Comments included: "My relative is well cared for here; they wouldn't be here if we weren't happy with it; they allow them to do as they please and respect their decisions"; "Staff are very good to residents; they are patient and kind"; "I cannot speak highly enough of the staff; they are caring and kind". All the comments were positive that we received.

On the day of our visit, we observed staff caring for residents in a respectful and compassionate manner. Staff were heard to use terms of endearment in an appropriate way and people responded well to this.

Most staff had a good knowledge of peoples' likes and dislikes. We saw one staff member assisting a resident back to bed, stating: "This person does not sleep well at night, so if they have a little sleep now they will feel better when they get up". Several staff were aware of this person's needs. Other staff were able to explain a person's preferred bathing routine which was reflected in their care records.

One person was continually saying they were waiting for their spouse to come home from work. A care worker approached them and spoke to them quietly and compassionately and was able to divert them, leading them gently away with the offer of a cup of tea. This person's anxiety level lowered due to the staffs caring and relaxed approach.

People's privacy and dignity was respected. We asked staff how they supported people to be as independent as possible. A member of staff said "it's their home and we respect that. We try to encourage them to do as much as they can. We do whatever they want us to do". Staff respected people's privacy by ensuring care was delivered behind closed doors and knocking to gain access to peoples' rooms.

As part of the provider's quality monitoring, we found people's opinions were sought through surveys and resident meetings. We saw the minutes of meetings that showed people's attendance and the discussions that took place. This helped ensure that people were able to raise any concerns or issues that they had, as people were asked for their views and reminded of the complaints procedure.

Surveys were completed yearly and sent to people living in the home, relatives, friends and external professionals. We looked at the results of the last one dated February 2014 which was before the significant changes in the staffing team. Overall the comments were positive and opinions were sought from people living in the home, relatives, visiting entertainers and staff. We were told if any individual comments required responding to, the manager would arrange to meet the person to discuss further. Compliment letters and cards were also viewed. Comments included: "thank you again for all your help and kindness". "The staff are amazing and supported [name] right to the end."

The home had a 'dignity tree' in the hallway of the home. This was a model of a small tree that everyone could hang comments on it's branches. All residents, families and staff had been provided with 'leaves' and were invited to add their comments about what they liked about the home, what they are not so keen on and what dignity meant to them. There were a number of leaves containing people's comments at the time of the inspection. Comments included; "Dignity is being treated with respect. I like [name] getting hugs and having fun. [name] laughs more than [name] has for years. I love the feeling of [name] being safe. Many thanks." "Like: The very caring attitude of all the staff and the quiet attention to personal care given in a sometimes very public area. Dislike: The seemingly constant use of TV/music at high volume without consultation of residents when nothing else is going on – maybe I miss quiet times!!". I love everybody here. I find anyone in Crossley so caring. The provider told us an action plan would be compiled to improve any areas that were required.

Requires Improvement

Is the service responsive?

Our findings

People's on-going health needs were not always managed. We saw one person who took a medicine which required regular blood tests to ensure the correct levels were given. However we identified this person had missed a blood test appointment. There were no records in the handover sheets or the person's own care plan to remind staff when the blood test was due. The manager stated they did make an appointment which was in the diary but it must not have happened and could find no reason why. Following our findings the manager arranged an urgent blood test for the following day. The manager assured us they would make a safeguarding alert as a result of this omission as this could have had a detrimental effect on their health and well-being.

Some people's change in health needs were not responded to quickly. We saw one person's care plan noted a referral to the falls team was required. However there was no documentary evidence to show that this had been done. We discussed this with a senior member of staff who confirmed no evidence could be found of any advice sought. Therefore no evidence could be provided to support that professional advice had been sought to support this person's change in need.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People's friends and relatives frequently visited. Visitors were welcome at any time and were able to join in any activities that took place. There was no activity coordinator in place, however the provider was undertaking recruitment to this post. We were told this was a newly created post as part of an overall review of the staffing arrangements. Care staff undertook activities with people as time allowed. Minibus outings took place and outside entertainers were used. Some people's activity care plans identified the activities that were available and suggested favourites. However recordings were not made on a regular basis to monitor the suitability and provision of activities for people, for example, one person had no recording since 2 October 2014. This meant it could be difficult to know if people's social needs were being met.

On the day of our visit, two residents went for a drive in the minibus, driven by a member of the maintenance staff. During the afternoon of our visit people were entertained by a performance of 'Jack and the beanstalk". This took place in the main lounge and was enjoyed by all.

Care plans showed that some people used bedrails. However we could find no assessments to demonstrate the need for bedrails had been fully assessed .We asked the senior staff to provide us with the details however none could be found.

People's care needs were assessed and personalised care plans were put in place. Plans provided details of all aspects of the person's daily living needs. This included: the person's life history, their health care needs, personal care needs and the social activities they liked to participate in. Care plans were reviewed monthly; one relative confirmed this took place. They told us they attended the six monthly reviews however they confirmed they visited regularly and could discuss any changes at any time.

Another relative told us how they were asked to attend a meeting the manager had called and involved other professionals in response to a concern they had with their relative. They told us they were included in all meetings and discussions and their views were taken into account. They also said staff keep them informed of any concerns or changes in their relative's care.

The provider had systems in place to receive and monitor any complaints that were made. A policy was in place that gave guidance for people to follow. People we spoke with told us they knew how to make a complaint if they wished. During our inspection a relative told us they were concerned with the amount of laundry that goes missing and clothes not being ironed appropriately.

They also said they were unhappy that what had been described as a quiet lounge prior to their relative's admission, where they felt would be able to sit quietly, was now used mainly as an office with people in and out all the time. We shared this information with the manager who agreed to discuss this further with the person.

Requires Improvement

Is the service well-led?

Our findings

Some members of staff said the home was not well led. They said they lacked support from the management team. One person told us "There is no structure to the day I have to do so many different things including cleaning and caring". A couple of staff told us they felt comfortable to raise things with the management of the home but confirmed they were aware of other staff concerns.

Comments from relatives were also mixed. One relative said: "It is difficult to seek information as the new manager is not forthcoming; they (the manager) stay in the background and don't make an effort, but passes things on to others to deal with". However people did tell us they would go to the manager if they had any concerns about their relative.

From information of concern we had recently received and the discussions during our inspection it was evident staff felt unhappy with the management of the home. They felt their concerns were not listened to or acted upon. People told us there was an atmosphere of discontent. One member of staff was concerned as they felt people living in the home were 'picking up' on the issues within the staff team as people have said "You are not going, are you?". Therefore people living in the home could feel unsettled with the high turnover of staff.

The senior management team were aware of the feelings of staff and a plan of meetings, both group meetings, one to ones and mediation sessions by an external provider were taking place. The provider acknowledged the potential impact this would have on the care of people living in the home and stated there was a lot of unhappiness in the staff team as there had been a lot of staff changes recently. They confirmed they were being supportive of all the staff members and management team.

Staff told us they had not received any formal minutes from the discussions with the management team to identify if any actions were going to take place. One person said "I gave my view and then nothing happens". Therefore without this taking place staff may feel their efforts were not listened to or acted upon. The provider agreed to consider compiling an action plan and communicate progress to the wider staff team. They also agreed to keep us updated with any progress.

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. We found the auditing of medicines was not robust with a number of shortfalls identified during the inspection. The quality assurance manager for the service undertook an audit every six months and the pharmacy that supplied the medicines box system undertook audits annually. However at the time of our inspection the manager did not undertake more regular checks and stock levels were not regularly audited. Therefore there was a risk of any discrepancies in people's medicines not being found quickly to enable staff to rectify them. This was identified with the manager during our inspection and they told us they were in the process of implementing such a system but at that time had not completed it.

There were not effective systems in place to reduce the risk and spread of infection. Cleaning schedules and infection control audits were not detailed or robust enough, to ensure effective cleaning took place. The manager undertook a weekly audit that included: health and safety, fridge and freezer temps, cleaning schedules and medicines. This was not effective as the concerns identified during this inspection had not been picked up during these checks.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Other audits were undertaken by the quality assurance and training manager that included: health and safety and training. These were undertaken on a monthly and quarterly basis. The system currently in place was aligned to CQC's 'Essential Standards of quality and safety'. The quality assurance manager told us this was now under review due to the recent changes in CQC methodology. We were told it will be a clearer and more robust method of auditing quality and assurance as it will be aligned to the five key questions. We looked at the outcome of an audit undertaken on 22 October 2014. We saw actions were recorded for the manager to take. For example, it stated staff were to complete people's weight and nutritional charts monthly and the manager to include this in their weekly audit. We crossed reference this and found this action had been taken.

The provider had systems to monitor the quality of the service. The provider undertook weekly visits to the home. This was used as an opportunity for the provider and manager to discuss issues related to the quality of the

Requires Improvement

Is the service well-led?

service and welfare of people that lived in the home. The weekly meetings were recorded and actions were set as required and followed up at the next meeting. This gave the provider a weekly update on all aspects of the service and provided support to the manager.

Staff told us they had team meetings and minutes were viewed that contained details of discussions and any actions that needed to take place. The manager told us any actions would be checked to ensure they were completed.

Staff we spoke with were unable to give any examples of how their input may have improved the service in any way. Staff were also asked for their views and opinions in the form of a yearly survey. Staff were given the opportunity to comment on the support they received, training and the home atmosphere. However from the results we saw only two members of staff completed for questionnaire that was dated February 2014.

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 People were not safe because the home was not clean and infection control policies and procedures of the home were not being followed by staff. This meant that people were at risk of harm through health acquired infections. 12(1)(a)(b)(c) 2 (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, dispensing and safe administration. Correct guidance on how medicines which are prescribed 'as required' (PRN) was not always followed. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Auditing systems were not robust in respect of medicines, care plans and infection control. Regulation 10 (1) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

	Sufficient numbers of staff were not on duty at all times to safeguard the health, safety and welfare of service users. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Not all records were completed fully. Some people's care files lacked recordings in relation to their care and treatment. Some people's nutritional records were not always completed comprehensively. This posed a risk to people's individual needs being met effectively. Regulation 20 (1) (1) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used the services were not protected against the risks of receiving unsafe care because professional advice had not always been sought to support people's change in need. Regulation 9 (1) (a), (b) (i) and (ii).