Maria Mallaband Limited

Water Royd Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place over two days 21 and 22 October 2014. Day one of the inspection was unannounced. The service was last inspected on 1 October 2013 where it was found to be meeting the requirements of the regulations we inspected at that time.

Water Royd Nursing Home is registered to provide care for up to 62 older people. There are three units; two on the ground floor and the third nursing unit is on the first floor.

On the ground floor one of the units is dedicated to supporting people who have a diagnosis of dementia. There were 54 people living at the home at the time of our inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

The quality assurance process within the service was not effective and this has resulted in improvements identified by audits not being implemented in a timely way. People using the service, relatives and staff raised ongoing concerns about the staffing levels at the home. The registered manager informed them that they were adhering to the company policy.

We were informed by staff that they had received training in safeguarding vulnerable people and when questioned staff demonstrated a very good understanding. CQC had been informed by the registered manager of any incidents and allegations of abuse. The registered manager and staff had followed correct procedures by referring allegations to the local authority safeguarding team and had taken action as directed by the local authority.

There was a lack of documentary evidence that relatives and the people who lived at the home had been involved in the planning of care. However the care staff and the deputy manager told us during annual care plan reviews the registered manager or the deputy manager discussed with the family members the care needs of people and updated them. Not all the people and relatives we spoke with said they had been involved in the care planning and reviews.

We spoke with relatives of people receiving palliative care. They told us that they were fully kept informed of the condition of their family members by the nurses at the home and the visiting MacMillan nurses. One family member said, “It is a lovely peaceful place and staff are very caring”.

The provider had an up to date plan to manage an emergency situation in the service such as fire or flood. Staff members we spoke with said, they were aware of the plans and had attended the necessary training to manage such situations.

Medicines were administered by registered nurses on the nursing unit and senior care workers on the residential units. We observed staff checking the medicines against the medication administration records (MAR) before administering medicine. We heard staff asking people whether they had any pain or discomfort and waited until the person replied before moving on to the next person.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict them. The registered manager told us that they had applied to the supervisory body for the deprivation of liberty safeguards for eleven people following the latest court ruling. Staff said they had received training and were expecting further training later this year.

We noted the cook and the kitchen assistants monitoring the food sent back to the kitchen after meals to find out which food was popular and which was not. The cook was very involved in finding out the likes and dislikes of people and also attending the residents and relatives meetings to obtain views about the food served at the home.

We carried out a short observational framework for inspection (SOFI) in the unit where people who had a diagnosis of dementia lived. SOFI is a tool used by CQC inspectors to capture the experiences of people who use services who may not be able to express or have difficulties communicating their experience of care. During our inspection we saw staff interacting with people in an encouraging way and distracting people when they became anxious and maintaining a calm atmosphere and promoted their wellbeing.

A new activities co-ordinator had been appointed two weeks before our inspection and they were settling into their post. On the first day of the inspection we saw people taking part and enjoying singing in the afternoon. However during the day we saw people looking bored and sitting asleep in front of the television or sitting in lounges without any stimulation.

Staff said when they received complaints they tried to resolve them as early as possible. The registered manager had records of the formal complaints they had received and the outcome of the investigations with lessons to be learnt. The manager told us they shared the lessons with the staff at staff meetings.

We found two 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 safe.

We observed staff to be competent in making sure people were safe and protected from harm. Staff informed us they had received training which helped them maintain safety and they had access to the necessary policies if they needed to check.

When staff administered medication this was not rushed. We heard staff asking people whether they had any pain or discomfort and wait until the person replied before they moved on to the next person.

Good

Is the service effective?
The service was effective.

Comments from health professional who visited the home were positive. People were supported to access other services to ensure their healthcare needs were effectively addressed.

Mental capacity assessments were in people's care plans. They were decision specific and reviewed appropriately to reflect people's changing needs. The registered manager had applied to the supervisory body for the Deprivation of Liberty safeguards for eleven people following the latest court ruling.

People told us they had plenty to eat and drink. We shared our observation with the manager that during meal time not all the people were supported in a timely manner by staff. This was rectified on the second day of our inspection by the registered manager.

Good

Is the service caring?
The service was caring.

Staff were friendly and caring towards people who lived at the home and maintained confidentiality and discretion.

Relatives gave us very positive comments about the staff involvement with care of their family members and how they supported them.

People told us they were treated with kindness and compassion by staff and did not experience any discrimination.

Good

Is the service responsive?
The service was not responsive.

Although people were asked for their preferences, it depended upon which staff and how many staff were on duty if people's choice had been met. Relatives and staff raised concerns about the insufficient staffing levels at the home and this resulted in people unable to receive person centred care.

Requires Improvement

Summary of findings

The registered manager told us that they had appointed a new activities co-ordinator. During the inspection we saw people looking bored and sitting asleep in front of the television or sitting in lounges for long periods without any stimulation.

People knew how to make formal complaints. There was a complaints procedure in place so people knew what procedures to follow.

Is the service well-led?

Requires Improvement

The service was not well-led.

The quality assurance process was not robust enough to ensure improvements were made in a timely way.

Relatives told us that their meetings did not happen regularly and there was a lack of action when improvements had been suggested.

Staff said they did not feel they were listened to by the provider or the registered manager. In the last two years the provider had not sought the views of the staff employed at the service.

Water Royd Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We inspected the service over two days 21 and 22 October 2014. On the first day, we arrived unannounced where the registered manager or the staff or the people who used the service were not notified of the inspection. This helped us find out a typical day at the service. At the end of the first day we informed the registered manager that we would be returning the following day 22 October 2014 to complete the inspection.

The inspection team consisted of two adult social care inspectors.

Prior to our inspection, we reviewed the notifications submitted by the provider and other relevant information we held about the service. We asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We requested information from the local authority contracting and commissioning team, local safeguarding team, community professionals such as district nurses, dietician, speech and language therapists and the local health watch team to find out their experience of the service. Local Health watch team is part of the local community and works in partnership with other local organisations to understand the needs, experiences and concerns of people who use health and social care services and speak out on their behalf.

We used various methods to gain information during our inspection which included talking with eight people using the service. We used the Short Observational Framework for Inspection (SOFI) to observe five people who were unable to speak with us and share their experience. SOFI is a tool used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. We spoke with four relatives and five visitors to the service, formally interviewed seven care workers, two senior carers, a registered nurse and the registered manager. We also spoke with the cook, kitchen assistant, deputy manager and the administrator. We checked the care records of six people, eight staff recruitment files, training records and staff rota for four weeks. We also looked at other information such as complaints and compliments, incident and accident reporting, monthly provider visit reports and quality audits of the service.

Good

Is the service safe?

Our findings

We asked five people who used the service and two relatives about their experience at the home in relation to safety. All five people told us that they felt safe because staff respected their rights. One person said, "I call staff if I want anything. I am safer here than I was in my own home." The relatives we spoke with said they were happy with the way staff treated their family members and did not have any worries.

We spoke with five members of staff. They were able to explain how they would report any allegations of abuse and demonstrated a good understanding and their awareness of safeguarding vulnerable adults. The registered manager told us that all staff had attended training on safeguarding. CQC had been informed by the registered manager of any incidents or allegations of abuse. The registered manager and staff had followed the correct procedure by referring all allegations to the local authority safeguarding team and had taken action as directed by the local authority. In the last 12 months there had been 11 safeguarding referrals made by the home. We found the registered manager and staff had taken appropriate steps to protect people who lived at the home to reduce the risk of harm.

Four people we spoke with said they felt staff members treated them without prejudice or favouritism. They said they appreciated that all of them had different needs and came to live at the home due to different reasons. One person said, "I see staff going to help some people more because I presume they need more help. But I don't feel neglected. I like it here and I am alright."

We looked at six care records, three from each unit. The records had detailed risk assessments with care plans showing how the risk was to be minimised and the care planned to meet people's needs. We saw examples of where actions were taken where needed to minimise risks and increase safety. A member of staff told us how they reduced the risk of a person having falls by referring them to the physiotherapist for specialist equipment.

We obtained copies of the personal emergency evacuation plans maintained for each person occupying the service. We saw they had been checked regularly and the last review was on 16 October 2014. This meant the provider had a system for the staff to follow in an emergency situation such as fire or flood. Staff members said they were aware of the plans and had attended the necessary training. The deputy manager told us that weekly fire drills were carried out and they ensured all staff had attended the drills at least twice yearly.

The registered manager informed us that they adhered to the company policy on staffing levels and that they used the dependency tool provided by the company to determine the numbers. However some relatives, people who used the service and staff disputed this and told us that the levels of staff did not reflect the needs of the people. The dependency tool used was not reflective of the needs of people. We commented on this and shared our findings from relatives and staff with the registered manager as the staffing numbers affected the delivery of care. The registered manager agreed to look into this.

We looked at five staff recruitment and selection files. We discussed with the registered manager some of the gaps we found, such as one staff member had only one written reference and this was from a colleague. There was no evidence that a nurse's personal identification number had been checked with the nursing and midwifery council. The registered manager and the regional manager told us that during the previous provider audit this had been identified and that they were in the process of auditing staff files. We saw the administrator had started working on staff files to ensure necessary information had been sought and the information was up to date.

The registered manager informed us that they had followed the Whistle Blowing policy when staff reported issues concerning other staff members. The registered manager described what action they took in response to the concerns raised. We saw that the manager had taken appropriate action in a timely manner to protect people who lived and worked at the service.

We checked the incident and accident reporting process at the home. The registered manager said that they checked all reports and submitted the information to the head office where they were analysed and they then received the outcome. The deputy manager said they took immediate action when accidents were reported to avoid them happening again.

We observed medication rounds on both floors. Medicines were administered by registered nurses on the nursing unit and senior care workers on the residential units. Senior

Good

Is the service safe?

care workers told us that they had received training in safe management of medicine and had been supervised by the deputy manager before they were allowed to administer medication.

Staff wore tabards when carrying out medication rounds to inform people not to disturb them. A tabard is an outer garment/ tunic which is used to ensure staff are easily identified. We observed staff checking the medicines against the medication administration records (MAR) before administering these. We heard staff asking people whether they had any pain or discomfort and waited until the person replied before moving on to the next person. For example on the unit where people with dementia lived, one person was not sure what to do with their tablets when they were given and they looked confused. We saw the member of staff sit next to the person, made sure they had a drink and gave them one tablet at a time and explained what it was for. The person was not rushed and they happily took the tablets. We observed several such examples during the medication round. This meant people were offered medicines at the time they needed and they were safely administered by staff.

We looked at three medication administration records. They were signed and dated and there was one gap where a medicine was not signed for, this was pointed out to staff that looked into it immediately and resolved the matter. One of the senior care staff explained how medicine was ordered and managed at the home. We noted checks had been made when medicines had been received and recorded on MAR sheets by staff. Medicines which were to be returned to the pharmacy were stored separately and collected by the pharmacy porter. However we noticed that the records of returned medicines were not signed and dated by both the staff at the home and the person from the pharmacy who was responsible for the removal of the container of medicine. This had also been identified at the last pharmacy audit in September 2014. The manager assured us that she would address this issue to ensure proper procedures were followed in future.

Medication was labelled and stored correctly. There was a wall thermometer in the medication room so that staff were able to check the room temperature. The medication fridge temperature was monitored twice daily and recorded by staff. The manager had ensured that staff were made aware of the temperature ranges so that medicines were stored at correct temperature.

Good

Is the service effective?

Our findings

We spoke with people who used the service, relatives and visiting professionals about their views and the effectiveness of the service.

People who used the service and relatives told us, “Some staff go that extra mile to help. But I cannot fault anyone. They work hard”. “My (relative) is at the end of life. You cannot wish for more caring and efficient staff. I know my (spouse) is kept comfortable”.

We received the following comments from the professionals. “I have no problems. Staff always listen to what I say and if they have any problems they do not hesitate to contact me and ask for further help. Very committed staff” and “I have been visiting this home for some time and I have always found staff very professional. I have no complaints”.

We were also informed by people that they were able to see the optician, chiropodist and attend other hospital appointments with the help of staff. Two members of staff said if a person did not have any family members to go with them they would go. This meant that people were supported to access other services to ensure their healthcare needs were effectively addressed.

We interviewed six staff members to find out their view of the training and support they received. Staff said most training they received was e-learning. Three said such learning did not suit their style of learning. Two other staff said they received practical training such as moving and handling, medication administration and as part of infection control, a ‘hand washing’ exercise. We asked the registered manager how they tested the competency of staff once they had completed e-learning and also shared the staff comments They said they did not currently have a system and were exploring ways to address this.

All six staff told us that they had received supervisions (regular planned one to one meetings with their line manager) and annual appraisals from either the registered manager or the deputy manager. This was confirmed when we checked the dates when six members last had their supervisions. One staff member said, “I talk about what went well and what training I want to do. If I have any worries about work this is an opportunity for me to talk about it.” Another staff member said, “We are asked for our suggestions and what we enjoy”. This meant that staff were supported in their roles and had opportunities to highlight and address any training and development needs.

We found the care staff had a good understanding of their roles and the differences between senior care workers and care workers. However, the managers told us there was a keyworker system in place. The intention of a key worker is to provide a focal point for the person using the service to provide consistency. The key worker is expected to get to know the person and their family and develop a rapport so that the person and relatives would be able to relate to the keyworker. We were informed by three people using the service, two relatives and four staff that this did not happen. This meant that although the managers had informed people that they had a key worker system this was not always apparent to staff, people who used the service and their relatives.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict them. . Staff said they had received training in this and were expecting further training later in the year. This was confirmed by the registered manager.

The registered manager, the deputy manager and the senior staff such as the nurses and senior carer workers had a good understanding of the requirements of the MCA and DoLS. The home was divided into three units and people’s needs and ability on each unit varied. The registered manager told us that they had applied to the supervisory body for the deprivation of liberty safeguards for eleven people following the latest court ruling. This meant people were cared for in an environment which took into account people’s mental capacity and their right to liberty.

We observed the way staff dealt with people’s behaviour that challenged others. We saw staff spending time with people who were agitated and diverted their attention to talk about things which interested people. They took people who were upset or agitated to aside to a quieter area away from others to minimise the negative impact on other people. Staff understood the difference between lawful and unlawful restraint practices. One example given

to demonstrate their understanding was the usage of bedrails to protect people from falling. Staff told us that if they used bedrails without getting the person or their representative's permissions/consent then it could be perceived as restraint as the bedrail prevents the person from getting out of bed.

We saw staff explaining and gaining consent before they gave support or care. They knocked on people's bedroom doors and got permission before entering their rooms. Before staff embarked on delivering care they got permissions form the person and made sure it was acceptable to them. Within people's care records we saw evidence where people's consent had been gained to take their photographs. Staff had a good understanding of why gaining valid consent was important. Two staff members said whatever they did if they did not gain consent it could be construed as abuse. One staff went on to say "it is not just telling the residents what I am going to do but getting them to understand and agree".

We observed lunch time (midday meal) on both floors. We had a mixed response from people who used the service about the meals served at the home and how meal times were managed. Mostly about the food not being warm and staff rushing around to serve them. We saw a member of staff taking two dinners to two people who needed help. They put one meal in front of one person and went off to help the other. The member of staff sat with this person and helped them eat, when they had finished some 15 minutes later, they went off to help the other person. This meant the second meal was not hot enough. This highlighted that meal time was not organised effectively to ensure people were getting the necessary help at the appropriate time. The regional manager said that they had looked into having two sittings to address this problem. Following our inspection the manager informed us that they had commenced two sittings from 30 October 2014 to utilise the staff effectively during meal times.

We saw staff completing food and fluid charts during the day. These were monitored by nurses, senior care staff and the deputy manager. Staff told us that they referred people to a dietician through their GP and offered different choices of food to tempt people if they were "off food". The records showed people's nutritional needs were assessed and plans were put in place to ensure people received a balanced diet that promoted their wellbeing.

We spoke with the cook who told us that they maintained a list of people's likes and dislikes and attended 'resident's and relative's meetings' to gain feedback about the food offered. We noted the cook and the kitchen assistants monitored the food sent back to the kitchen after meals to find out which food was popular. The menus were on a three weekly rota. We saw there was a good choice of food offered to people. Snacks and drinks were also made available throughout the day. Five people told us they had plenty to eat and drink and they had no complaints. One person commented, "They don't over face me by giving me a plate full. I mostly like the food but at times when I had asked for something else I have been given what I wanted. I think they are very good".

Good

Is the service caring?

Our findings

People told us they were treated with kindness and compassion by staff and did not experience any discrimination from staff. They said they were able to have visitors without any restrictions. One person said, “My (spouse) comes to visit anytime which is convenient. There is no problem”. Two relatives made the following comments. “Staff are very caring and respectful of people and speak with the older people in a caring and considerate way”. “I see them laughing and joking but never seen the staff make fun of any one. They are funny but they know where to draw the line. I have a lot of admiration for the staff; I can’t do their job”.

We were informed by staff that they had received training in equality, diversity, gender and ethnicity. The training records confirmed this. One member of staff said they cared for the people as thought they were their family members. Another said they knew people well and were able to understand and give them appropriate emotional and physical support. They said how they found a cup of tea and a chat settled people down. A further member of staff said, “I always enjoy when I work in care. We are a good team. We really like making these people enjoy their days and not be worried about anything. Older people tend to worry”. Observations during the two days of our inspection confirmed that staff respected people’s diversity and treated them with respect and maintained people’s dignity. Staff created an atmosphere which was calm and homely for the people who lived at the home.

We carried out SOFI in the unit where people who had a diagnosis of dementia lived. We observed staff interacting well with people. We saw that staff knew the people well and spoke with them in a manner which was respectful, friendly and inclusive. Staff had a good understanding of each person’s behaviour pattern. Care records from this unit had information about people which illustrated their past life, important people and events in their life. Staff with the help of the families had written on people’s care files, information which was important to understand and help people. During our inspection we saw staff distracting people when they became anxious and maintaining a calm atmosphere. We observed staff talking to people about their families, looking at photographs of the family and informing people news about their family such as where they had gone on holiday or when the family was visiting This meant people were able to have a relaxed and pleasant experience.

We observed staff to be friendly and caring towards people. They maintained confidentiality and discretion when relatives enquired about other people who lived at the home. There were policies and procedures in place to ensure staff understood the importance of confidentiality. During our interviews we noticed staff had a good understanding and appreciation of the need for this. One member of staff said, “This is a close knit community and it is very important that we maintain confidentiality. Especially those who have dementia when they are not always in control of what they are doing or saying.” Two relatives said they had every confidence that staff maintained their professionalism and did not breach the confidentiality of people they cared for

The registered manager told us that although they had contact with advocacy service none of the people at the home were in receipt of this service as all the people had relatives who were there to support or make decisions on behalf of them. Advocacy service supports and enables people to express their views and concerns, access information and services and helps to defend and promote people’s rights and responsibilities.

The relatives we spoke with said they were fully aware of the care needs of their family members and felt staff took care of their needs in a sensitive way. One relative said, “I know the staff well and they know me and we make sure my (spouse|) gets the care. The staff are good and attentive”.

We spoke with relatives of people receiving palliative care. They told us that they were kept fully informed of the condition of their family members by the nurses at the home and the visiting MacMillan nurses. They said they were aware of the care plan and that staff told them if there were any changes to the treatment. Relatives commented that nurses and care workers were very caring and kind. We observed several examples of sensitive care practices. We observed staff attending to a person who was receiving end of life care. Staff quietly entered their room, went up to them and explained who they were and what they were there to do. Although the person kept their eyes closed and did not respond staff kept talking to the person as they attended to their needs.

Requires Improvement

Is the service responsive?

Our findings

We looked at care plans on all three units. We took into account the dependency levels of people and the nursing aspects of care on both floors and our observations highlighted the care practices between the two floors were not consistent. We found on the ground floor units the care plans were personalised. Individual's needs were clearly identified and risk assessments were completed. Plans included how to minimise the risks and deliver care and support appropriately. However on the nursing units not all risk assessments were up to date and therefore it was difficult to demonstrate that care delivered to people reflected their current needs.

We were informed by people from both floors that they remembered staff talking about what help they wanted and making notes and they were happy with the arrangements. However two people who used the service told us that they did not know they had care plans and said that they had not been consulted with by staff. We informed the nurse on the unit of our findings.

We found that there was a lack of documentary evidence such as signatures on care plans to show that relatives and/or the people who lived at the home had been involved in the planning of their care. The care staff and the deputy manager told us that during annual care plan reviews the registered manager or the deputy manager discussed the care needs of people with the family members and updated them. However the lack of documentary evidence meant the registered manager was unable to evidence that the people and/or their relatives had been involved in care planning and reviews. Therefore the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

We saw that the care records identified people's likes and how they preferred their care to be delivered. The care plans had been reviewed by nurses, the deputy manager or the registered manager when changes were implemented and also on an annual basis. The care records we checked had been reviewed in September 2014 by the registered manager. Care staff told us they were informed of people's needs, at handover. Care workers told us that they did not get the opportunity to read the care plans before hand and relied on the handover information.

We interviewed staff and we found care workers' knowledge of the people they were looking after depended upon the unit they were working in. Care workers on the residential unit were confident and demonstrated that they knew sufficient information about the people and they said they would ask their senior if they were not sure. However, care workers on the nursing unit said they were confident of the tasks they needed to complete during their shifts rather than knowing about the individual person's care needs. This meant care workers on this unit were not enabled to deliver person centred care. For example staff kept a bath record and made sure all those who wanted a bath on that day did receive one. However they did not take into account if people wanted a bath in the morning, before breakfast, in the evening or at bedtime. Further comments by people on the nursing unit supported our findings.

We were informed by five people their choice and preferences depended upon which staff were working and how many staff were on duty. We received a varied response from the people who lived at the service about them receiving individualised care. One person who lived at the home told us that they liked lying on top of their bed before lunch. They said staff knew that and helped them "get on the bed". Another person said they were able to ask for a shower when they wanted but did not necessarily get it at their preferred time and another person said they were able to go to bed and wake up when they wanted to as they were able to manage by themselves. A family member told us that their relative got ready for bed early evening but did not settle down to sleep until late at night and it was their choice to be dressed in night clothes during early evening and staff supported this. Another person said, "I know staff can't always come running as soon as I call for help. But I sometimes get a little fed up of waiting but I know it can't be helped. They are sometimes short and always busy". This meant there was a lack of consistent approach to the delivery of care at the service.

The registered manager told us that they had appointed a new activities co-ordinator. We met with the activities co-ordinator who used to work at the home in a different role. They knew the people and they were in the process of developing records of individual's likes and dislikes of activities and social events. On the first day of the inspection we saw people taking part and enjoying singing in the afternoon. However during the day we saw people looking bored sitting asleep in front of the television and

Requires Improvement

Is the service responsive?

sitting in lounges without any stimulation. Two relatives and three people who lived at the home told us that there were not enough meaningful activities for people. We had the following comments. “People are sat waiting for meals and then bedtime. Nothing else for them to do. Care workers come up sometimes and chat. That is the stimulation they seem to get”, “You should see people who sit in front of the TV everyday if they like it or not. The programmes are not always appropriate. Sometimes staff came into the lounge sat and watched telly without talking to anyone. People need more interaction and proper stimulation”. During our inspection we observed young people from school seconded to spend time at the home sat in lounge watching TV with people. We shared this feedback with the registered manager so that they had the opportunity to address the concern.

We saw that the provider’s complaint policy was displayed on each floor and staff knew how complaints should be handled. People told us they knew how to make formal complaints. One person said they would rather tell the person who had done wrong to their face and sort out the problems. Staff said when they received complaints they tried to resolve them as early as possible. The registered manager had records of the formal complaints they had received and the outcome of the investigations with lessons to be learnt The manager told us they shared the lessons with the staff at staff meetings.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who is also a registered nurse in charge of the day to day running of the home.

We found there had been a number of audits by the registered manager, the staff at the service and the monthly monitoring visit by the provider. However not enough action had been taken to demonstrate the findings had led to improvements and where improvements had been made; these had been monitored and sustained.

We were informed by the registered manager that the quality assurance manager carried out a monthly quality audit of the home and produced reports. We saw the last two reports which were detailed and had highlighted the action required to improve the service. However the improvements had not been progressed in a timely way. During our discussions with the regional manager and the registered manager we found out the main reason for the lack of progress was that responsibilities for the improvement actions were not devolved to staff within the service; since the registered manager was trying to implement all the necessary improvement themselves. This meant the registered manager did not have the time to manage the implementation of improvements and monitor progress.

The following examples highlighted the need for a suitable quality monitoring system to take note of the problems identified and ensure improvements were made in a timely manner.

We found there was irregularity in the process of the medication return. This had been identified four weeks before our inspection by the pharmacy audit and no action was taken.

People had complained of getting cold food for several months and the registered manager was aware of the problems at meal times; however only after our inspection of 21 October 2014, action was taken to address this. Care staff had told the managers (the registered manager and the deputy manager) that they did not feel e-learning was beneficial to them and staff were disappointed no action had been taken.

We were informed by the registered manager that staff were able to take part in an on-line staff satisfaction survey. Three staff members said they did not feel that completing the survey was of any benefit to them. A further three staff members said that they could not remember the last time they had a satisfaction survey from the provider. We asked the registered manager for the last year's 2013 results of the staff survey. They told us that they did not have staff completing the surveys and therefore did not receive any feedback. This meant the provider had not ensured staff who worked at the home had been consulted to find out their views of the service.

People who used the service and relatives told us that they had attended resident's and relative's meetings where they had discussed areas for improvements. Relatives told us that the meetings did not happen at dates and times they were available to attend and would prefer the meetings to be on different days at different times so that people who were at work during the week were able to attend. They said that the same comments came up every time and there was a lack of progress by the provider. The main areas of concern were the lack of staff presence on the units over the 24 hour period and the lack of stimulation and meaningful social activities for people.

One relative said, "There is always a lack of staff presence at weekends and Bank holidays. I am told the nights were often left short of staff as well." Another relative told us that at weekend staff had to keep the connecting doors to the units on the ground floor open as there were not enough staff on duty. These comments highlighted that there was a lack of supervision of people by staff during specific shifts which could lead to avoidable accidents and needs of people not being met. We looked at the staff rotas for two previous weekends and there was no indication of staff absenteeism. We shared this information with the registered manager who informed us that they have had concerns about staff not turning up on duty at weekends and other holidays. Therefore they had made a rule that all staff members must inform any sickness or absents to either the registered manager or the deputy manager so that they were aware of the staffing numbers throughout the 24hours. This meant the registered manager or the deputy were always aware of the staffing situation at the home.

We were informed by staff that they had staff meetings but they were not regularly held. They said staff meetings were often used to instruct them to do things and inform them of what they were doing wrong and how to improve. Comments by staff included "It would be useful to know

Requires Improvement

Is the service well-led?

what we do well and why people are happy to be here." "Not all of us are treated alike; there is a lot of favouritism. I don't feel the management listen to us". Two more staff said they had made comments about staffing levels and none of the managers wanted to listen to them. They were told that they provide sufficient staff and that staff "needed to manage their work and stop complaining". We looked at the last minutes of the staff meeting and found the comments by the staff were accurate. We spoke with the registered manager and the regional manager who explained that they were managing staff disciplinary procedures and due to confidentiality they had not discussed with staff what actions were being taken and this meant staff were of the opinion they had not been listened to. They also accepted that they would review the tone of staff meetings so that staff felt listened to and appreciated for their contribution.

We looked at the application of the dependency assessment tool used by the service with the help of the registered manager and the regional manager. We identified that there were eleven broad questions to be answered for each person who used the service in order to calculate their dependency. All of us agreed that the eleven questions as they were did not recognise the complexity of the people's needs at the home. For example, under question number two. Transferring position, there were three options with scorings, first transfers without help, second with some help and the third needs complete assistance. There was no account of how many staff were required to carry out the transfer, whether any aid was needed or a hoist was to be used. This meant the system was not comprehensive enough to accurately identify and calculate the dependency levels of people. This had resulted in staff adopting a task orientated care style to ensure all people's care needs were met each day. The regional manager agreed to look into it.

The provider had ensured a quality monitoring system was in place to gather information on the quality and safety of the care, treatment and support the service provided to people who lived and worked at the service. However our evidence showed that information was not always sought from staff and people and there was a lack of follow up action on identified areas for improvement. Therefore the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

We saw evidence of learning from incidents, accidents and complaints. The registered manager had records of the analysis and the learning outcomes. Staff told us these were shared with them on a one to one basis and also at staff meetings to help to avoid or minimise further occurrences.

The registered manager informed CQC of any incidents or accident affecting the people who lived or worked at the home without delay. These included injury to people using the service, any application to depriving someone of their liberty, allegation of abuse and police investigations.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The system in place to identify, monitor and manage risks to people who use, work in and visit the service was not robust. There had been a number of audits to monitor the service. There was a lack of action by the provider to ensure improvements were carried out in a timely manner. There was insufficient evidence, that the provider had sought the views of staff in relation to the standard of care and support provided to service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Accurate records of each service user were not maintained at the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.