Laudcare Limited

Oaktree Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 8 and 9 June 2015. We had been due to follow up the breaches of legal requirements that we found in February 2015, however we had a number of concerns raised with us because of hospital admissions and 'whistle blower' information. A whistle blower is a member of staff who works for the service and had reported concerns but not been listened to. They had therefore contacted CQC and told us about their concerns.

Oaktree Care Home is registered to provide personal and nursing care for up to 78 people. The service is divided over two separate floors. The ground floor is for those who require nursing care and the upper floor is dedicated to those people living with dementia. At the time of our inspection there were 27 people living on the upper floor and 34 on the nursing floor.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

The providers own recruitment policy and procedure had not been followed and this meant that people could be at risk of being looked after by unsuitable staff.

Care records were not accurate or detailed enough and could potentially mean that people would not receive the care and support they specifically needed. Communication between staff handing over to the next shift needs to be improved to ensure the ongoing healthcare needs of people are met appropriately.

All staff received safeguarding adults training. The staff team were knowledgeable about safeguarding issues, and had taken the appropriate actions when concerns were raised. They had reported events promptly to the local authority and CQC. At the time of the inspection there were a number of safeguarding investigations still ongoing. The appropriate steps were in place to protect people from being harmed.

A range of risk assessments were completed for each person and appropriate management plans were in place. The premises were well maintained and all maintenance checks were completed.

The registered manager monitored the staffing levels on both units and based the staffing numbers on the care and support needs of each person in residence. All staff felt that the staffing numbers were now appropriate, they were able to meet people's needs and their safety was not put at risk.

All staff completed a programme of essential training to enable them to carry out their roles and responsibilities. New staff completed an induction training programme and there was a programme of refresher training for the rest of the staff. Care staff were encouraged to complete nationally recognised qualifications in health and social care.

People were supported to make their own choices and decisions where possible. Where people lacked the capacity to make decisions, assessments were recorded of best interest decisions. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

People were provided with sufficient food and drink. Their specific dietary requirements were catered for and extra food was provided for those people who did not eat well. There were measures in place to reduce or eliminate the risk of malnutrition or dehydration, but improvements were needed with the monitoring of records. Arrangements were made for people to see their GP and other healthcare professionals when they needed to.

The staff team had good friendly relationships with the people they were looking after. People were able to participate in a range of different activities and external entertainers visited the home. The service only had one activity co-ordinator, one was currently not available to work and a third member had recently been recruited.

There was a staffing structure in place and the staff teams in both units were led by a unit manager. Regular staff meetings were held in order to keep all staff up to date with changes and developments in the service.

The registered manager had a regular programme of audits to complete which ensured that the quality and safety of the service was checked. These checks were completed on a daily, weekly or monthly basis.

We found a number of 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not completely safe.

People could be at risk because robust recruitment procedures are not consistently followed. The risk of recruiting unsuitable staff was therefore not reduced.

People received care from staff who were trained in safeguarding and recognised abuse.

Staffing levels on both units are calculated based on the collective needs of people in residence. There were enough staff to keep people safe.

People's medicines were being managed safely.

Is the service effective?

Good

The service was effective.

People were looked after by staff who had received the relevant training and felt supported by their colleagues and the registered manager. They received regular supervision to monitor their work performance.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The appropriate applications had been made to the local authority and were waiting to be processed.

People were provided with sufficient food and drink. They were supported to make choices about what they ate and drank.

People were supported to see their GP and other healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness and were at ease with the staff who were looking after them.

The care staff had good relationships with people and talked respectfully about the people they looked after.

Is the service responsive?

Requires improvement

The service may not always be responsive.

People may not always receive the care and support that meets their specific needs. Care planning documentation did not provide an accurate or detailed account of what support was needed or what care had been provided.

Summary of findings

People in both units were able to participate in a range of social activities despite there being a temporary reduction with the number of activity staff. Care staff provide individual support and stimulation as and when needed.

People were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Good

The service was well led.

Improvements were required to ensure that management instructions were followed through and addressed. The service was in breach of two regulations.

There was a programme of checks and audits in place to ensure that the quality of the service was measured. Any accidents, incidents or complaints were analysed to see if there was any lessons to be learnt.

Oaktree Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and was undertaken by two adult social care inspectors. At the previous inspection in February 2015 we had found significant failings and breaches in relation to a number of areas. These were:

- safeguarding,
- management of medicines,
- meeting nutritional needs,
- treating people with dignity and respect,
- the planning and delivery of care arrangements,
- the quality assurance systems,
- notifications of events not being sent in to CQC and
- staffing levels.

Prior to the inspection we looked at the information we had received from the local authority safeguarding team and notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us.

During our inspection we spoke with 10 people living in Oaktree Care Home and five relatives. We spoke with one GP and the supplying pharmacist who were visiting the home at the same time as our inspection. We also spoke with other people who were visiting the home in connection with work they were carrying out. We spoke with the two unit managers, four nurses, eight care staff and one activity coordinator. We spent time with the registered manager, the area manager and the provider's care quality facilitator.

We conducted a Short Observational Framework for Inspection (SOFI). SOFI provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves. We did this because those people living with dementia were no able to tell us about their experiences of living in Oaktree Care Home.

We looked at nine people's care documentation and other records relating to their care. We looked at six staff employment records, training records, policies and procedures, audits, quality assurance reports and minutes of meetings.

Requires improvement

Is the service safe?

Our findings

People told us, "They keep us safe here", "We don't have to worry about anything", "Everyone is very kind and gentle with me. I couldn't ask for better care" and, "I am helped when I ask for assistance. Sometimes I may have to wait for a while because they are busy, but they help me as soon as they can".

Staff we spoke with were aware of their responsibility to keep people safe. They told us, "We have been trained to use the hoists properly", "One of us has to be in this area (a sitting area) whenever people are here to ensure they are safe" and, "We have recently changed the way we work with one person's behaviours, in order to keep them safe".

Of the six staff recruitment files we looked at two showed that the provider's own recruitment policy had not been fully adhered to. The recruitment records for these two staff members showed that the pre-employment checks had not been properly completed. In both cases written references had not been obtained from the person's most recent employer. For one staff member it was unclear in what context the written reference had been provided (employer or personal reference). Prior to this inspection we were advised by the registered manager that a risk assessment had been undertaken in respect of one staff member. This staff member, after starting working at the home, had advised the reasons for leaving their previous employment. There was no risk assessment in place.

All staff records included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. Where there had been information recorded on the DBS for one person there was no evidence that an analysis of the risk had been made. The registered manager agreed that a risk assessment to determine the staff member's suitability to work with vulnerable people had not been carried out.

This meant the provider had not ensured all staff were suitable to work with vulnerable people.

This was a breach of regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

People were kept safe by staff who knew about the different types of abuse and what action to take when abuse was suspected, witnessed or a person made an allegation of harm. Staff were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of the sort of things that may give rise to a concern of abuse.

There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Some of the staff thought it would be useful to have the safeguarding contact telephone numbers displayed in the staff room, so they could report direct if they had concerns. Staff we spoke with told us they had completed an on-line training programme in keeping people safe and safeguarding adults. Staff knew about 'whistle blowing' to alert management to any poor practice they knew about.

Since the last inspection in February 2015 there have been 14 safeguarding alert records set up. Six were raised by the registered manager and were in respect of events that had occurred in the service. Other alerts were raised by healthcare professionals and family. The registered manager had reported correctly and taken the appropriate action to prevent a reoccurrence where possible. The local authority were still in the process of completing their investigations for some of those alerts. There was on- going safeguarding monitoring in place by the local authority because of the high number of concerns since the beginning of the year.

A number of risks assessments had been completed for each person. Assessments had been completed in respect of the possibility of skin damage caused by pressure (also known as bed sores), the likelihood of falls, risks of malnutrition and moving and handling tasks. Where a person needed the care staff to support or assist them with moving or transferring from one place to another a moving and handling plan was devised. These set out the equipment required and the number of care staff to undertake any task.

Personalised risk assessments were completed where appropriate. Bed rail assessments were completed to determine whether they were safe to be used when the person was in bed. In some cases the bed rails were considered to pose a greater risk and were not used. In this event the bed was kept at its lowest level with a soft mat by the side of the bed. Many of the beds we saw when we looked around the dementia unit were kept at the lower

Requires improvement

Is the service safe?

level and soft mats were used. People were screened to see if there was a risk of choking and where required a management plan was in place to reduce or eliminate that risk.

Personal emergency evacuation plans (PEEP's) had been prepared for each person: these detailed the level of support the person would require in the event of a fire and the need to evacuate the building. All the PEEP's were kept in a folder in the main reception area.

The maintenance person had a programme of checks to complete on a regular weekly or monthly basis in order to keep the premises safe. The registered manager ensured these checks had been completed. Whilst there was remedial works ongoing in the home, there were measures in place to ensure that people were not placed at any risks. The kitchen staff recorded fridge and freezer temperatures, hot food temperatures, food storage and kitchen cleaning schedules.

The staffing numbers in both units were six care staff and two nurses in the morning and five or six care staff and one nurse in the afternoon. These arrangements were confirmed in the staff rotas. According to the staff, staffing levels had consistently been at the higher rate following our previous inspection in February 2015. The registered manager used a dependency tool to calculate safe staffing levels. The registered manager reviewed staffing levels when people's needs changed or a new person moved to the service. They said as a minimum it was reviewed monthly and was forwarded to the regional manager for them to agree. Comments we received from the staff included, "Downstairs we have enough staff to care for people safely", "Staffing levels are usually fine" and, "There are arrangements in place to enable one of the seniors to move upstairs now if we have to give one person 1:1 care for a period of time. We all work together much better now". Care staff told us, at the beginning of their shift they were allocated to work in specific areas of the home and with specific people.

People were administered their medicines by nurses at the prescribed times. We observed the nurses in both units administering medicines to people safely, ensuring the correct medicines were given to the correct person. People were provided with the level of support they needed and it was evident that the nurses knew how people liked to take their medicines. If people required their medicines to be crushed or to be given covertly this was detailed on the MAR chart. On the dementia care unit, the two nurses each did part of the medicine round at the same time in order to ensure that people's morning medicines were administered at the correct time. Despite this the process of administrating medicines to everybody still took nearly one and half hours. One nurse told us that one person's morning medicines had been moved to the lunch time because they did not like to wake until late morning and this fitted in with their daily routine properly.

Prior to the inspection we had been told that one person had not received their medicines for a significant period of time. Their care records and GP notes confirmed that all medicines had been discontinued by the GP at the end of April. The person, who had capacity to make this decision, had requested this as part of their end of life care.

The pharmacist told us there had been a "definite improvement" since they had last visited the service six months previously. They said PRN protocols were now in place and the medicine administration records (MAR charts) did not show any gaps in signatures. PRN medicines are those medicines given as and when needed, for example pain relief. The pharmacist had made a recommendation that the temperature in the downstairs clinical room be monitored to ensure medicines are stored at the correct temperature and the reason for PRN administration be included on the MAR chart.

There were safe systems in place for the ordering, receipt, storage and disposal of all medicines. There were suitable arrangements in place for storing those medicines that need additional security. Records showed that stocks of these medicines were checked regularly and could all be accounted for.

Good

Is the service effective?

Our findings

Not every person we spoke with was able to tell us whether the care and support they received met their needs. Others commented, "I get the help I need", "I am well looked after and couldn't ask for anything different" and, "Everything is perfectly OK".

Training records showed staff received a range of training to meet people's needs. Newly appointed staff completed an induction training programme at the start of their employment. An induction checklist ensured staff had completed the necessary training to care for people safely. Staff members told us they received regular training and felt it helped them do their jobs better. Staff said they were well supported and were, "Doing so much better now than when we (CQC) last visited".

All care staff were encouraged to undertake health and social care qualifications. A number of staff told us they were doing their level two or three diplomas (previously called an NVQ).

There was a plan in place for all staff to receive supervision and the role of supervisor was shared between the registered manager, the two unit managers and senior care staff. The registered manager supervised the nursing staff, with the unit managers and seniors supervising the care staff. One member of staff told us about 'Instant supervisions' – this was where a member of staff had been seen to do something which could be done better, for example serving food without an apron on. There were two types of supervision - clinical and performance supervision. The registered manager would carry out the performance supervisions. Staff gave mixed feedback on their supervision. A registered nurse told us they did not find the performance supervisions useful. One care assistant said, "(Unit manager's name) does my supervision. I find it helpful". Staff supervision records contained records of discussions with staff on improving their performance.

We observed people at lunchtime in both units. Since our last inspection two sittings had been implemented. This had resulted in a quieter meal time experience, with the staff being able to assist people individually. There was plenty of staff in the dining area. People were offered a clothes protector and where this was declined the person's wishes were respected. In the dementia unit the meal choices were written up on the noticeboard but there were also pictures of the meals on the tables. The tables were laid up nicely in readiness for the meal. Staff were friendly, attentive and served food in a respectful manner.

People were chatty, seemed to enjoy their lunch and appropriate music was playing quietly in the background. The food was hot and appeared appetising. There was plenty of drinks (squash and water) on the tables and tea and coffee was offered to people after the meal. People said they enjoyed the food. One person told us, "I'm vegetarian so always have a veggie option, which is usually good". Another person said, ""The food's not always what I'd choose but it's OK". A third person told us, "The food is good". One staff member was assisting a person to eat. The staff member ensured the person ate at their own pace and spoke to person throughout. When lunch was finished in the dining area staff supported those people who had remained in their rooms to eat. We saw other care staff supporting people to eat their meals, this was being done sensitively and kindly.

The catering staff felt there had previously been a problem with communication between the care team and the kitchen staff but this had now improved. The catering staff were aware of who had specific dietary requirements. Since the last inspection the way that pureed food was served had been improved. However, the catering staff were not using moulds in order to present food on the plate. There was confusion about whether there was a Four Season's policy that moulds were not to be used and this will be investigated by the registered manager and area manager.

Snack boxes were available on both units and regularly topped up by the catering staff. People who had not eaten well at the meal times were offered crisps or chocolate. One person said, "I really love these. What are they?" The member of staff told her they were quavers and gave her another packet "for later". The person smiled.

People were able to make their own choices and decisions about their care where possible. Where people lacked the capacity to make decisions, assessments were recorded of best interest decisions. The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA legislation provides a legal framework for acting and making decisions

Good

Is the service effective?

on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to care or treatment.

Information in people's care files showed the service had assessed people in relation to their mental capacity. Some staff, including nurses and those in senior care roles had not received training on the MCA and said they would benefit from this. This was discussed with the care quality facilitator at the end of the inspection who spoke about a training programme being implemented for all staff. When we spoke to staff they understood their obligation to support people to make choices and decisions. The service had supported people through a process of 'best interest' decision making to ensure they received health care interventions they required. This process had involved the staff, health and social care professionals and family members.

The service was applying DoLS appropriately. The provider had submitted DoLS applications appropriately. At the time of our inspection there were three DoLS authorisations in place and the service was waiting for a further 18 to be processed by the local authority. Three of the applications were dated as far back as December 2014 and we discussed this with the registered manager. He agreed to contact the appropriate manager in South Gloucestershire Council to discuss moving these applications forward.

People told us they had access to other health professionals and staff would organise health appointments if they were unwell. A foot care specialist visited the service on a fortnightly basis. People were registered with GP's from seven surgeries. One of the surgeries told us they visited the home every week and saw those people who needed a doctor appointment. When administering medicines one of the nurses identified a person needed to see a GP. She talked to the person about this and gained his consent to contact the doctor. She asked the unit manager to contact the surgery and stated the need to insist the doctor visited. The GP visited the person later that day. The nurse later said, "The surgery are not always keen to come out but (Person's name) needed to see the doctor today". This showed that nurses ensured people received the healthcare support they needed.

One GP told us, "The top floor (the dementia unit) used to be absolutely chaotic and it is much calmer now". They said that the unit manager had made significant improvements and communication was better with the nurses.

Good

Is the service caring?

Our findings

People told us the staff were caring and friendly. Comments we received from people in the nursing unit included, “Staff are very caring, they’re lovely”, “The staff are great” and. “The staff are really good, they’re all nice and very caring”. One relative said, “My mother likes to spend time in her room but the staff check on her and are very caring”.

Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. We saw a number of positive interactions and saw how these contributed towards people’s wellbeing. For example, a care worker spoke to a person who was walking the corridor and seemed quite confused, the member of staff asked if they were all right, listened to their response carefully and assisted them to talk with a more senior member of staff. Another example involved the registered nurses administering medicines who both spoke to people in a very caring manner. From people’s reactions it was clear they enjoyed the interaction and conversation.

In the dementia care unit one person had a period of agitation. A member of care staff consoled them and was sat with them stroking their hand and singing along with them. The person was smiling during this engagement. Whilst the medicines were being administered we saw that one person declined to take their medicines. A member of care staff spoke gently to the person whilst kneeling at their side and talking about a child relative and a dog – the person then became engaged and took their medicines.

Staff knocked on people’s doors and either waited to be invited in, or if the person was not able to answer, paused for a few moments before entering. People’s bedroom doors and the doors into bathrooms and toilets were closed when people were receiving care. One staff member said that in the last six months there had been greater opportunity for them to be able to sit with people and chat. This was because there were more staff available.

The chef told us that when it was people’s birthday a birthday cake was made for them and the staff sang Happy Birthday. There were 10 birthdays in June to celebrate.

Care plans showed people had been consulted on the care and support they received. One person in the nursing unit and their relative told us they had been involved in developing their care plan and their views on avoiding hospitalisation had been taken into account. As part of the care planning process people were asked by what name they preferred to be called and what things were important to them. This information was incorporated into their care plans. Examples of things in people’s plans were their style of dress, food choices and ‘what I like to do and talk about’.

Requires improvement

Is the service responsive?

Our findings

People were supported with their care and support needs when they needed assistance. They said, "I use my call bell when I need to use the bathroom and the girls come and help me", "I just have to ask and they help me with whatever" and, "Oh yes everyone helps me here". Relatives we met said, "I feel my mother is well looked after. We visit regularly to keep an eye on things and would speak out if it wasn't the case". One relative had raised concerns with us prior to the inspection as they were not happy with their way their relative was looked after. The issues raised were in the process of being investigated by social services.

Each person's care and support needs were fully assessed before admission to the home. This was to ensure that the service was able to meet the person's individual needs and that they had any specific nursing equipment (hoists, specialist beds or movement sensor equipment for example). The assessment covered all aspects of the person's daily life, specifics about how their dementia presented and any nursing care needs. A care plan was written, based upon the assessment details.

Where people were funded by either the local authority or health services, information was gathered from them as to the person's needs. These documents identified the type of care the person needed and the level of any risks. Care plans covered the person's mental capacity, mobility, nutrition, personal hygiene and dressing needs, continence, skin integrity and where appropriate, end of life care needs.

People's care plans did not always reflect their needs accurately. For example, one person's care plan stated they should always have a snack during the night to maintain their blood glucose level. Their daily records did not state they had received a snack the previous four nights. The unit manager told us the person only required a snack if their blood sugar levels were below an identified level. Records showed the checks had been carried out and were satisfactory. Other examples included records not giving sufficient information to support decisions made. On one occasion a person was admitted to hospital even though their care plan stated they were "not for hospitalisation". We were able to talk with the nurse who had been on duty at the time of the person's transfer to hospital. They told us the on-call doctor asked the person about hospital and they had agreed to go. Records obtained from the doctor confirmed this discussion.

Care records did not always provide an accurate and detailed account of the care and support provided. Where people were prescribed creams or ointments, they were applied by the care staff. A separate creams chart was used to record the application and was kept in their room folder. Nurses however recorded on the MAR charts the code F which meant that 'carers sign'. For one person F was recorded on the MAR every day but the chart in the room stated 'not needed' or 'not required'. Other charts kept in the room included positional change charts and food and fluid intake and output forms. The positional change charts we looked at were adequately completed. The fluid intake forms were not totalled at the end of a 24 hour period and there was no evidence the nurse in charge had been informed if fluid intake had been low. For one person their recorded intake was 100mls and 140mls for two consecutive 24 hour periods, but the staff had recorded 'offered but refused' drinks. We checked other records regarding this person: the person clearly had capacity and chose not to eat and drink and their GP was aware. The registered manager was unaware that the nurses were not checking the room charts at the end of their shifts.

Safeguarding concerns were raised by hospital and ambulance staff following a person being admitted to hospital. There had been a lack of communication between the day staff who had been on duty when the on-call doctor visited, and the night staff when the ambulance arrived. Important relevant information had not been relayed to the ambulance staff. Although the staff said a hospital transfer letter had been completed, a copy was not made. It was unclear how much information had been detailed in this documentation. However, if this had contained a clear and detailed account of the person's health needs, the safeguarding concerns would not have been raised. Poor record keeping and communication had led to another safeguarding concern being raised by the hospital at the same time.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Daily handovers were taking place between staff. A handover is where important information is shared

Requires improvement

Is the service responsive?

between the staff during shift changeovers. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach. We sat in on the handover from the night nurse to the day nurse on day two of the inspection. The report was very brief however the day nurse had worked the evening before and knew the people well. The night nurse explained the handover report would have been fuller and in more depth when required.

People's needs were reviewed regularly, or as required, by the nurses and care staff who recognised when people's needs had changed. People were encouraged to have a say about their care and support and to speak up if they were unhappy about anything or wanted things done differently. Where necessary the health and social care professionals were involved. An example of this was one person who was referred for a seating assessment so that they could safely and comfortably in an armchair.

There was a weekly programme of activities for people to participate in and a copy of the programme was displayed in the main reception. Each person was provided with a newsletter on a monthly basis and this included a copy of the activities programme. The service currently only had one of their three personal activity leaders (PAL's) in post. One of the PAL's was currently not able to work and the other had left. A new PAL's had already been recruited and was due to start work the following week. During the course of our inspection 'pat-the-dog' visited and there was also an external entertainer who provided an enjoyable sing-along session that approximately 25 people joined in with. The hairdresser visited each week and there was a church service on a monthly basis.

Good

Is the service well-led?

Our findings

People who were living with dementia were not able to tell us whether they thought the home was well-led or not but made the following comments: “Things are alright”, “The girls are always there to help me” and, “It must be because things happen every day as they should”. People in the nursing unit said, “All the staff are very good and know what they are doing” and, “The manager (the unit manager) is very good to me”. One relative we spoke with said, “The unit is a lot better organised now that the lead nurse has settled in”.

The registered manager led a care team of two unit managers, eight qualified nurses and 39 care staff. There were also housekeeping, catering, maintenance and administrative staff employed. The registered manager had a long career in care, managing extra care housing complexes and care homes. He had completed a level five qualification in leadership and management. The two unit managers worked a combination of shifts and supernumerary hours in order to fulfil staff supervisions and other management tasks.

Staff said the service was, “Much better”, “Less chaotic now the staffing numbers were right” and “The unit manager has settled in now and we are working better as a team”. Staff said the registered manager was approachable and was often available at the weekends as well as during the week. Staff said they worked in either the nursing or dementia care unit and this enabled them to get to know each person well. There was some movement between the two units but on the whole they worked within the same teams. Staff told us that teamwork on the dementia care unit had improved greatly since the last inspection.

Regular staff meetings were held to keep them up to date with changes and developments. Separate meetings were held with senior staff, kitchen staff, domestic and laundry staff and all staff. We looked at the minutes of previous meetings and saw a range of areas were discussed. Staff told us they found these meetings helpful and that generally the registered manager was receptive to any suggestions they made. We noted that in the staff meeting held on 13 March 2015, it was stated that the nurses were to check and sign the food and fluid charts at the end of their shift. This area still requires improvement.

The registered manager visited both units every day. Since the last inspection in February 2015 mobile tablet devices were being used to record the outcome of the daily walk-about. As part of this walk- about 10 sections had to be completed. This included an assessment of the environment, a check of the clinical recordings and comments made by the staff and people spoken with. In the absence of the registered manager this task would be undertaken by the nurse in charge. The tablet device was located in the main reception area and could be accessed by relatives, people living in the home and visitors who wanted to make comments for the registered manager and the provider to see. The tablet device was also used to record a number of audits and checks that had to be completed.

In order to monitor the quality of the service there was a programme of audits in place. The senior housekeeper and chef had a monthly audit to complete and submit to the registered manager. Weekly and monthly audits were completed in respect of ‘resident care’ and care plans, medicines and weight loss. Care plans were reviewed on a monthly basis by the nurses and care staff in order to ensure people continued to receive the care and support they needed. The service had a ‘Resident of the Day’ scheme in place. On this day the identified person was visited by catering, housekeeping, maintenance and the care staff and all aspects of their care and support was reviewed.

Accidents, incidents and any complaints received or safeguarding alerts made were logged in to the quality assurance reporting system. They were followed up to ensure appropriate action had been taken. The registered manager analysed these to identify whether any changes were required as a result of any emerging trends, in order to prevent or reduce reoccurrences.

The registered manager and unit managers were aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the home and which the service is required by law to tell us about. The registered manager had been informed by CQC at the beginning of May 2015 that notifications about deprivation of liberty applications had to be submitted when the outcome of that application was known.

A copy of the complaints procedure was displayed in the main entrance. It was also included in the information

Good

Is the service well-led?

about the home, given to people on admission or their relatives. Some people would know what to do if they wanted to raise a concern or complaint whilst others were unable to engage with us when we asked them what they would do if they were unhappy about something. The provider's complaints procedure stated all complaints would be investigated and responded to in writing.

The policies and procedures we looked at had been regularly reviewed. Senior staff we spoke to knew how to access these policies and procedures.

A care quality facilitator employed by the provider visited on the second day of the inspection. The purpose of their visit was to discuss progress on key areas for improvement with the registered manager. They said the main areas requiring improvement were being worked on. They said the key areas at present were implementing a new care planning system, medicines management, monitoring weight loss and nutrition, and introducing pictorial menus. They also told us, "The care documentation is much better downstairs, mainly because the nursing team have been together for longer".

Following our last inspection in February 2015 the registered manager had written an action plan however it was not easy to follow and did not relate to the specific issues referred to in the report. The plan told us about the improvements they had made and were going to make however these were not always clear. We will be asking the provider and registered manager to submit an action plan following this inspection to tell us about the steps they will take to rectify the breaches in regulations we found.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed. The registered person must ensure that recruitment procedures are established and operated effectively to ensure that person's employed are of good character. Regulation 19 (1) (a) and (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014:Good governance The registered provider must ensure that accurate, complete and contemporaneous records are maintained in respect of each service user. This includes a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c).