CareQuality Commission

Majesticare (Oak Lodge) Limited

Oak Lodge 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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on 13 September 2016.

Oak Lodge Care Home provides a service for people who require personal and nursing care. The home is able to accommodate up to 47 people. The building is divided into two parts. The main part provides nursing care to older people and The Acorns provides care to up to eight people who are living with dementia. At the time of the inspection there were 40 people living at the home.

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

Although people said they felt safe, we found some examples which placed people at risk of unsafe and inconsistent care. For example, the service did not always have enough suitable staff to consistently meet people's needs in a timely manner. A relative, who visited the home most days, said although they felt their relative was safe and well cared for, there were times when the home was short staffed and people had to wait some time to be assisted. The clinical director and manager accepted staffing arrangements needed to be explored due to the high dependency of some people living at the home.

Staff told us they did not get enough quality time to spend time with people. They said whilst they did talk with people during tasks they were unable to give them any extra time. Staff spoken with raised concerns that they did not have time to, "Just sit and have a chat", they felt the main social interaction was left to the activity coordinators. During the inspection call bells were often ringing for more than seven minutes and staff were seen to be busy delivering care and carrying out tasks only.

We looked at the way people's medicines were managed and stored. Medicines were administered by registered nurses and care coordinators. Medicines were kept securely in locked medicine trolleys which were stored in locked treatment rooms when not in use. However we checked people's records and stock levels during our inspection and found some of these to be incorrect. The manager carried out an immediate investigation.

Some people who required assistance to take their medication told us sometimes they did not receive their medicines when they were due. One person said "I waited until 10pm and they still didn't come". Staff told us not all staff were trained to administer medication, which meant people had to wait until the registered nurse or care coordinator were available to administer the medicines. This meant people were at risk as medicines were not administered in accordance with the prescriber's instructions and at the suitable times.

There were inconsistencies and inaccuracies in people's care records, including how people's risks were monitored. This meant people may not have received the care they required. The provider's quality assurance system had not operated effectively in identifying and making changes without delay when improvements were needed.

Throughout our inspection staff showed kindness and consideration to people. When staff went into any room where people were they acknowledged people. Staff had a good rapport with people and were seen to be friendly. When staff supported people they spoke to them in a kind and calm manner. One member of staff took time to play a few tunes on a piano in a lounge area; this gave enjoyment to a person sat in the room, who had received little interaction throughout the day.
"One person said, "Staff are very good on the whole, I love it that they all know my name and say hello [name] how are you today".

Staff had the skills and knowledge they needed to meet people's needs. They had received training at the start of their employment on how to recognise and report any suspicions of abuse. They said they were confident they could speak with the manager or provider about any concerns and they would listen and take action. One member of staff said "I would know how to report any abuse and would do so without hesitation."

People were able to take part in activities with minimum risks to themselves and others. A member of staff told us, "We are supported by the new manager and often see senior managers around the home; they always enquire how the activity programme is going. We have a budget and we also fund raise. We share a mini bus with another of the homes; it is great for community links.

The provider had a system in place for responding to people's concerns and complaints. People and relatives told us they knew how to complain and felt assured that staff would respond and take action to support them.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

People's needs were not always met in a safe, consistent and timely way due to the levels and deployment of staff.

Some people were at risk of not receiving their medicines at the time prescribed and the stock of some people's medicines had not been safely managed.

People were supported by staff who had been appropriately recruited.

Is the service effective?

Good

The service was effective.

People had their nutritional needs assessed and received the support they needed at mealtimes.

People's legal rights were protected because the provider was working in line with current legislation designed to protect people's rights.

People were supported by staff who had the skills and knowledge to support people.

People's health needs were monitored and met as they had access to appropriate healthcare professionals

Is the service caring?

Good

The service was always caring.

People were supported by kind and caring staff

People were involved in their care planning and making decisions.

People were encouraged and supported to maintain family

relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care records were not always accurate or complete which meant care being delivered could not always be monitored.

People were supported to make decisions about their daily lives and activities they wished to participate in.

People, relatives and staff were able to express their views and the service responded appropriately to feedback or complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's quality assurance system had not operated effectively in identifying and making changes without delay to address areas for
improvement.

People were supported by a motivated and dedicated staff team and accessible and approachable management team.

Care Quality Commission

Oak Lodge 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 took place on 13 September 2016 and was unannounced. It was carried out by two inspectors and a specialist advisor (a registered nurse).

Before the inspection took place we asked the provider to complete a form called a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We looked at the information they gave us, and all other information we had received about the service since the last inspection, including notifications and safeguarding alerts.

During the inspection we spoke with eight people who lived there, six relatives, the clinical director, the manager, the deputy manager and fifteen members of staff. We also spoke with one health professional visiting the home. Before the inspection we received contact from two professionals who regularly visited the home.

We looked at records relating to the care and services provided by the staff. These included recruitment records, staff training records, daily handover records, staff rotas, menus, care plans, and records relating to quality monitoring and improvement. We also looked at records relating to the maintenance and safety of the building.

Requires Improvement

Is the service safe?

Our findings

There were risks that people's needs were not being met in a timely manner. For example, during the inspection, call bells were often ringing for more than seven minutes, We heard on a number of occasions people calling for help but staff were busy delivering care to other people. One person told us, "When I ring my bell it takes a while for staff to come, this means I can't always get up or go to bed when I want to". Another person told us "I ring my bell when I need help, they [staff] don't always come". We also saw some people were still requiring personal care when the lunch was being served. One relative said "[person's name] has not had any personal care or anything to eat this morning and now lunch is here". Another relative also felt their relative had not received any personal care before their lunch was served

We found the staffing levels in The Acorns of particular concern. There were seven people living there, everyone was receiving residential care but they had complex needs and were living with dementia. They were supported by one member of staff throughout the day. Staff, who all worked there at different times, told us they were unable to consistently meet people's needs safely. For example on the day of the inspection, three people asked the one member of staff for support at the same time. They were therefore only able to help one person at a time which meant the other two were still asking for help.

One relative, at The Acorns told us, "We are doing extra visits as we have been worried about [person's name] support. It is nearly dinnertime and they still have not received any breakfast". When we were shown around The Acorns at around 10.45am a person who was sat in the lounge with another person, immediately told the manager they were hungry. Whilst the manager arranged for the person to have some breakfast there had been no staff in the lounge as they were busy doing other jobs. People's needs were not always able to be met safely, for example. One person who had become upset began to wonder without the aid of their walking frame, looking for support. The staff member was behind closed doors supporting another person. This meant the person was unable to find the support needed and also put them at risk of falling.

There was one registered nurse to provide the nursing needs for 33 people. Whilst The Acorns was the residential side of the home, the nurses still had a responsibility to ensure people were safe. This was confirmed in the minutes of a staff meeting held in July. The registered nurses and staff told us there used to be two registered nurses on per shift. This had been reduced to one; however the provider had created a care coordinator role. These staff received additional training and they supported the nurses by taking on some of their tasks. They also coordinated the shifts to ensure they ran smoothly which freed up the nurses time to be spent solely on nursing duties. However, the registered nurses told us it was still difficult to carry out all nursing duties on their own.

We discussed the issue of staffing with the manager and the clinical director. The manager told us they can be called upon if necessary. The manager also felt staffing was assessed appropriately and according to people's needs. They said their method of working out staff numbers and skills included considering people's needs, mobility and risks. The clinical director said "If it shows in our assessments that we need more staff we will look again at the budgeted numbers for the home."

This is a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People in The Acorns told us they did not always receive all of their medicines. For example on the morning of the inspection one person told us they sometimes did not get their evening medicines which were due at 8pm. They told us this often happened. They informed us they had not received their medicine the previous evening, they said. "I gave up waiting at 10pm, they [staff] told me this morning they didn't bother as I was asleep". Records showed where medicines had been missed, and staff agreed sometimes people did not always get their medicines before they fell asleep. They felt this was because not all staff who worked on Acorn had received the appropriate training to administer medicines. Therefore people needed to wait for the registered nurse or senior member of staff to administer them which often meant people had gone to bed. This meant people were at risk as medicines were not administered in accordance with the prescriber's instructions and at the correct times.

We looked at the way people's medicines were managed and stored. Medicines were administered by registered nurses and care coordinators. Medicines were kept securely in locked medicine trolleys which were stored in locked rooms when not in use. There were suitable arrangements for medicines which needed additional security or required refrigeration. The provider had an appropriate medicines policy and procedures. All staff administering medicines had received training in the correct procedures to follow and a competency check was carried out to ensure they remained up to date with current best practice.

However, we read medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. We checked these records against stocks held and found them to be incorrect. For example a discrepancy in the controlled drugs book, showed signatures stating there should have been five vials in a box when there were only four. There were no records on the medication record sheet (MAR) to show any administrations. No member of staff spoken with was aware of the error. We discussed our concerns with the manager who carried out an immediate internal investigation.

Each person had a folder in their room where staff recorded care tasks and other monitoring such as people's positions in bed and their fluid and food intakes. People's risks had been assessed and provided clear guidance to staff on how to reduce people's risks. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents.

Staff understood people's risks and were able to describe them and how to manage them. For example, people at risk of skin damage through pressure had guidance describing how to manage this. One person's records stated the person was to be repositioned every two hours and recorded. We found the recording for this person varied in recording from three hours to sixteen hours. Staff could not confirm if the person had been repositioned every two hours or if it was a lack of recording. Whilst the person had no pressure damage, the inconsistency of record keeping meant, the monitoring of the care for this particular risk would not be possible from reading the records.

This is a breach of Regulation 12 (1) (2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks of abuse to people were reduced because the provider had good recruitment procedures. Appropriate checks were completed before staff started working at the home. These included written references from previous employers and carrying out Disclosure and Barring Checks (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people. Records confirmed these had been

completed and any gaps in employment were explored to ensure they were appropriate. Staff told us they were unable to work at the home until these checks were completed.

Staff knew how to recognise and report abuse, they told us they knew what to do if they suspected someone was being abused, mistreated or neglected. They had received training at the start of their employment on how to recognise and report any suspicions of abuse and safeguarding vulnerable adults. They were able to describe various types of abuse and said they were confident once reported the registered manager or provider would listen and take action. One member of staff said "I would know how to report any abuse and would do so without hesitation." The provider also had policies in place which gave staff contact details of relevant agencies, such as the local authority and CQC.

Risks associated to the environment and equipment were reduced because regular maintenance checks on the home and equipment were completed. These included checks of the fire alarm system, fire fighting equipment. Safety signs were in use to prevent trip hazards. The home was well maintained and appeared clean and tidy throughout.

Good

Is the service effective?

Our findings

At the last inspection in February 2015 we found improvements were needed to ensure people's legal rights were fully protected. For example, best interest processes had not been followed fully when deciding to use pressure mats to alert staff when people moved around their room. At the time of the inspection, the then registered manager had also not been up to date about changes in the law regarding the deprivation of liberty rules. This meant that some people were being deprived of their liberty without the correct authorisation to do so. At this inspection, we found these issues had been addressed. However, further improvements were still needed.

People's legal and human rights were not always fully protected because the principles of the Mental Capacity Act 2005 (MCA) were not being used appropriately. The Mental Capacity Act 2005 provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available.

Whilst assessments on people's capacity had been completed for wide ranging topics they were not completed in line with the principles of the MCA codes of practice. For example one person had a capacity assessment for almost every area of need rather than being decision specific, one had the heading sensory impairment but the form did not state what decision was to be made and what the final outcome was. Whilst this did not impact on people, the proper process should be followed to ensure decisions made on behalf of a person are made in line with the MCA codes of practice. The manager told us this format was the provider's system but they were in the process of auditing all plans.

We recommend that the MCA codes of practice are adhered to when assessing people's capacity and decisions are being made on behalf of people.

Staff had received training about the MCA. They were able to tell us how they supported people to make decisions for themselves on a day to day basis. Where people were unable to make a decision staff consulted with relevant professionals and family members, following best interest processes. We observed staffing always explaining to people, in a patient and clear manner, what they were doing and asking people if it was ok to deliver the care or support.

People can only be deprived of their liberty to receive care and treatment which is in their best interest and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). The home had appropriate policies and procedures regarding the Deprivation of Liberty Safeguards and applications had been made.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Where concerns were identified with people's nutrition, staff sought support from professionals such as GP's and speech and language therapists. We observed the lunchtime experience during our inspection.

The dining room catered for a small number of people, others were supported in their rooms. The manager told us more room could be made available in the main dining room if people wished to eat there, but the majority of people choose to remain in their rooms.

Meals were served from a trolley with ban- marries to keep the food warm. There were two meal choices available. The kitchen staff told us they had a list of everyone who was on a special diet, from low sugar to various textured diets, as well as people's likes and dislikes. We were told staff decided for people who were unable to express a choice. One person was heard saying they did not like what was being offered to them. A meal of their choice was provided. Some people who were hesitant to eat were encouraged to eat at a pace which suited their needs. Staff who took meals to people in their rooms remained with them to provide assistance. Down stairs three people needed assistance to eat in their room, whereas upstairs eight people required assistance. Hostesses were available on the upper floor at lunchtime to support people with their meals as required. Staff told us they were often short at this time but they would not compromise the time it took to assist a person. They said the food stayed warm in the ban-marries.

Staff completed an induction when they first started working at the home. They also shadowed more experienced staff and worked through an induction booklet. This covered information about the provider, HR topics, and all aspects of caring for people and managing risks, and essential health and safety subjects such as fire, infection control and manual handling. It also included information about CQC and what we look for during inspections.

In addition to this staff completed other training, for example, safeguarding, dementia, duty of care, person centred support, end of life care, communication, and equality and inclusion. Staff spoke about how this training had changed their practices. One staff member said "it's about putting people at the heart of everything you do". Another said "I now understand that people living with a dementia can't always help their behaviour, they need more support".

Staff received regular one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

People had access to external healthcare as required. Records demonstrated the service had worked effectively with other health and social care services to help ensure people's care needs were met. The manager had made appropriate referrals to health professionals including GPs and members of the multi-disciplinary team as required. One visiting health professional told us the home had contacted their team as they were concerned they hadn't received a care plan for a person who had been assessed by the team recently. The Health care professional said "Staff appear to know the residents well".

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring and treated them with respect. Although staff were busy and found it difficult to spend time with people being sociable, they displayed a friendly, kind and caring approach towards everyone. When we asked if staff were caring one person said, "I like living here, the staff are kind". Another person told us, "I am always treated with dignity and respect by the staff".

Staff told us they always treated people how they would want their relatives to be treated. They said they become frustrated when they are unable to spend quality time with people but always tried to make any interactions positive. One member of staff said, "It crazy, not enough staff to sit and chat with the residents, but I like working here". Staff respected people's privacy and did not enter people's rooms without their permission. They also confirmed they received training about respecting privacy and dignity. One member of staff told us "It's not hard; you treat everyone how you want to be treated yourself". Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in an affectionate and respectful way.

Staff supported people in a patient and reassuring manner when they assisted people who needed help with mobility. We observed staff ensuring people were comfortable and in the correct position at the end of any transfer.

Care plans described people's individual communication needs, decision making capabilities and things they enjoyed or disliked. People were encouraged to express their views and preferences to the extent they were able. Regular meetings were held with relatives and people in the home to enable people's views to be heard and news to be passed on. For example, at the meeting in September 2016, people had said they would like a monthly lunch club outing; this was being trialled and if successful would continue. Where people had limited communication skills the views of close relatives or other people who knew them well were taken into consideration. For example, relatives at the same meeting had been involved with people in agreeing for a projector and screen to be purchased out of residents funds. This was to enable events to be screened on a large screen and to hold cinema activities. One relative discussed how they had talked about what their relative liked to do at the initial assessment with the manager, which meant staff were able to understand the person's interests and hobbies.

People were encouraged and supported to maintain family relationships. People's relatives told us they were made to feel very welcome when they visited the home and were encouraged to be involved in their relative's care planning. Relatives said they could visit at times convenient to them, there were no set visiting times or unreasonable restrictions.

Each person had a single room where they were able to spend time alone or see visitors. Rooms had been personalised to make them more homely and suit people's individual tastes and preferences. Communal areas were clean and decorated with tasteful furnishings and decorations. People who lived in Acorn had memorabilia on the walls, such as scarves, beads and pictures of olden times. One person told us "I like my room and like to come and sit in here for some peace."

People had the equipment they required to meet their needs. There were hand rails around the home to enable people to move around independently. Where needed, people had access to walking frames and wheelchairs. A lift was available to assist people with different levels of mobility to access all areas of the home. Access to The Acorn was through a door with a key code. People living at The Acorn were able to leave the area to join other people in the nursing home or join in activities in the nursing side of the home. One person said, "Staff are very good on the whole, I love it that they all know my name and say hello [name] how are you today

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to all of their needs because staff were not always available in a timely way. One person was supported to move in a chair when they had slipped down. The staff member involved then played the piano for a few moments. The person was seen to engage well with this interaction. Unfortunately these social interactions were few and far between and were only for brief periods of time. Staff were task focused and did not sit and talk to people for any meaningful period of time. We observed people alone in their rooms or lounge areas for long periods without any additional interactions from staff. Many people spent their time quietly or sleeping unless they needed care or they were given a drink, snacks or a meal.

Whilst some people went out with the activities coordinator the majority of people had very little social interactions. Staff said they did not get enough quality time to spend time with people chatting. They said whilst they did talk with people during tasks they were unable to give them any extra time. They also told us some people's personal care was just finished before lunch. The manager told us they ensure people have their breakfast and drinks before personal care is given unless the person chooses to get up first.

The service employed three dedicated activity co-ordinators. Weekly activity schedules were seen around the home for all to see the activities for the week. On the day of the inspection a planned trip to the seaside was taking place. One person told us they were looking forward to their trip out on the mini bus for a fish and chip lunch. The manager told us in their PIR, family and friends are encouraged to visit and participate in the activities, they said, "We have three very enthusiastic and engaging activities staff, who are trained to enhance life styles for all people". An activity coordinator told us, "We are supported by the new manager and often see senior managers around the home; they always enquire how the activity programme is going. We have a budget and we also fund raise. We share a mini bus with another of the homes; it is great for community links.

People who were unable to access the community had other activities arranged inside the home. OOMPH sessions (Our Organisation Makes People Happy). A specialist exercise which uses music and simple routines for people with more physical and mental health issues. Staff who had been trained to support the activity told us they enjoyed doing the routines and also felt people liked joining in. One member of staff told us, "It is an easy exercise to engage with people if I am lone working. "The home also benefited from a pets corner, which included guinea pigs rabbits and chickens.

People had links with the local schools by participating in The Archie Project. The Archie Project is an intergenerational dementia awareness project and it links schools and care homes and people with dementia together within the community. An activity coordinator told us, "We have made good links with local schools, people love interacting with the child and the children love our pet's corner.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. From the initial assessments support plans were devised to ensure staff had information about how people wanted their care needs to be met.

Relatives told us they had been fully involved in the initial assessment. The manager told us they were happy to carry out the assessments in people's home or hospital. The manager told us it was important to ensure they could meet the needs of the person before they were admitted to the home.

After the initial assessment, a detailed care plan was drawn up identifying the person's background, preferences, and support needs. The detailed care plans were stored in the nurse's station on the ground floor. The manager and deputy manager were currently changing the format of the care plans. They informed us they were planning on making the care plans more person centred. In addition to the care plans each person had a personal file. Care staff were responsible for recording each time they provided any care or support. In addition to the care plans and personal care files, nursing staff noted key facts about people's health and well-being and any changes to people's care requirements. This information was used to brief staff at each morning and evening shift handover meeting.

Each person received a copy of the complaints policy when they moved into the home. One person said, "No, up till now I have never needed to complain, but if I did I would complain to the manager or their deputy". The manager told us there was an open and honest culture in the home."

The provider sought people's feedback and took action to address issues raised. Any issues raised from the feedback questionnaires were dealt with and people and relatives informed of the issue raised and action taken.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since March 2016. They had made a lot of changes in the home which the majority of staff felt were positive. However, the improvements were still on-going. Further improvements were also needed to ensure the quality assurance systems by both the manager and the provider were more effective. For example, the current quality assurance systems had not picked up the medicine stock error we identified. Whilst audits on people's care records were being completed, these were not completed therefore the inconsistency in record keeping had also not been picked up. The consequences of staffing numbers and deployment had not been addressed by the manager or provider in an effective manner.

The manager had the support of a clinical director who supported them with the development and every day running of the home. The clinical director informed us they were in the home on a regular basis. Staff told us they often saw the clinical director around and found them to be very approachable.

As part of the governance arrangements, the provider had a "Monitoring of Business Performance Policy and Procedure" which set out areas expected to be monitored by the manager. For example, complaints, pressure ulcer incidents, review of previous month's action plan, review of reports from other agency's such the fire department and environmental health. In addition, staffing issues such as supervisions, sickness and absences formed part of this policy. As well as menus, hygiene, cleaning records and maintenance issues. The manager showed us a list of audits they completed which were in line with the policy and were one of the methods they used to monitor the quality of care. For example medication, care plans, infection control and accident audits were completed. Following these and depending on the outcome, notices were put up for staff to read or issues found were addressed at meetings. For example issues relating to medication administration were raised at a staff meeting in March. Since then the system for the administration of medicines had changed and improved.

A representative from the provider carried out monthly checks on the home. These included checking the experiences of people living at the home, by speaking with people, visitors and staff and observing care. The checks also covered areas such as management issues and progress, dementia care provision, business development, HR issues and operational issues such as complaints and health and safety. They also identified good things that had happened in the home that month. However, these audits and quality monitoring systems had not identified a number of the areas for improvement found during our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

Following the review and checks, a report was produced with recommendations and or action plans. We read the reports for July and August 2016. There was a mixed level of detail in each. For example, in July's report the heading – Is the service Responsive? stated "They work hard to make sure residents are not feeling isolated – I evidenced staff encouraging residents to join in activities". Whilst this was positive it did not describe how many people were being encouraged and if they were people who were in their rooms. During this inspection we found many people in their rooms alone for long periods.

In the July report – under the heading of Dementia Care Provision there were subheadings, for example "Practical" which stated "The environment, reminders, LPA docs", under the heading of "Social" – it stated – Staff approach, staff training, engagement with friends and family, spiritual support". Under the heading "Emotional" it stated – Humour, short term pleasure, living for the moment". It was not clear what these brief details meant and how they had reached these conclusions. Under the heading of "Leadership Team Overview", the July report had extremely limited details of what was looked at. Whereas in the August report much more detail was given about the audits checked and it described actions taken. These inconsistencies meant that unless it was the same person carrying out the reviews each month, it was not clear what had and had not been checked. The lack of detail also meant the provider was not given a level of detail that provided assurance.

The manager also held weekly heads of department meetings to be kept up to date and to pass on information. Staff meetings were also held. We read the minutes of meetings held in March which identified areas for improvements and introductions of new practices. For example medication records required improvements and a new handover sheet was introduced to cover important issues to be passed on between shifts and to keep the manager informed. Further staffs meeting were held in July where issues relating to recruitment and peoples well-being were discussed with staff.

Staff spoke positively about the manager, saying they were approachable, they listened and "they were getting things done". Since joining the home many staff had moved on, this meant that 60% of the team had only been working at the home for approximately six months. Staff told us the manager or deputy manager always walked around the home at least once a day to check people were ok and ensure there were no issues and to check if their help or support was needed. The manager also worked occasional shifts which helped them understand the pressures during the shifts, but also to see if any improvements could be made. Some staff felt they would have liked to see the manager work around the home more. The manager told us they had to balance working on shift against their responsibilities as a manager. They said they felt they had the balance right by working 60% management and 40% on shift.

There were clear lines of staff responsibilities and everyone spoken with understood their responsibilities. Registered nurses and senior carers worked within teams where they held responsibilities for reviewing people's care as well as providing support and supervision to named staff. Staff told us they felt well supported by their mentors and they either received one to one supervision with them or other staff were still going through their probationary period.

The manager told us their visions and values of the home were, "They wanted people to live the life they want to and by choice". They also added that they felt it was important that staff looked after each other by listening and always being approachable and to ensure they treated people in the home how they would want to be treated themselves. Staff spoken with during a handover of shifts expressed how they always tried to work by thinking about how they would want and expect their loved ones to be treated.

People's views on the service had been sought by way of satisfaction surveys and resident meetings. The last meeting was held in August 2016. People were supported to discuss and choose what activities they wanted to take place in the forthcoming months. The activity coordinator told us, "People have said at the meeting they would like to a monthly lunch out". These activities had already commenced at the time of the inspection.

The manager understood their legal duty to notify CQC about significant events. As far as we are aware they have notified us appropriately of all serious incidents and events.

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 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 RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to manage and reduce risks to people, ensuring medicines were administered, in accordance with prescriber's instructions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The system to assess, monitor and improve the quality and safety of the service was not operating effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified , competent, skilled and experienced person were not deployed in order to meet people's care and treatment needs.