Shires Healthcare (Woodside) Limited

Woodside Nursing and Residential Care Home

Inspection report

The Old Vicarage
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Luton
Bedfordshire
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Tel: 01582423646

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16 March 2016

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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 carried out 23 February 2016 and 16 March 2016. It was unannounced.

Woodside Nursing and Residential Home provides care and accommodation for up to 27 people, some of whom are living with dementia. At the time of our inspection there were 19 people living at the home.

The home had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The service was not always safe. People did not always receive their medicines as they had been prescribed and medicines administration records were not always correctly completed. Medicines were not therefore managed in a safe way. In addition the home had not been cleaned and maintained to an acceptable standard to prevent the risk of infection. Improvements had been made and more had been planned to both the level of cleanliness and the maintenance of the building to reduce the risk.

People had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met. Although care plans were reviewed on a monthly basis they were not updated following receipt of advice from other healthcare professionals until the next monthly review. This did not ensure that people were provided with appropriate care at all times.

People had enough variety of nutritious food and drink available to them. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly.

Staff were aware of the safeguarding process. There were enough skilled, qualified staff to provide for people's needs. The necessary recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They received training to ensure that they had the necessary skills to care for and support the people who lived at the home and were supported by way of supervisions and appraisals.

Staff were kind and caring and protected people's dignity. Staff treated people with respect and supported people in a way that allowed them to be as independent as possible.

The quality assurance system was not robust. There was no documentation to show that actions were taken to address areas identified as requiring improvement during the regular audits and the same areas for

improvement had been identified in subsequent months. Documentation was often incomplete and this had not been identified.

Information was available to people about how they could make a complaint should they need to and the services provided at the home. People were assisted to access other healthcare professionals to maintain their health and well-being.

People were asked for feedback about the service to enable improvements to be made.

During this inspection we identified that there had been breaches of Regulations 12 and 17 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 the 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 always safe.

People did not always receive their medicines as they had been prescribed.

An acceptable level of cleanliness had not always been maintained.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People were supported to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives may not have been involved in the development and review of care plans to ensure that they were person-centred.

People were supported to follow their interests and hobbies.

people were aware of the provider's complaints policy. .

Is the service well-led?

Requires Improvement

The service was not always well-led.

Care plans were not updated to reflect advice given by healthcare professionals outside of the monthly review cycle.

The quality assurance system in place was not robust and actions needed to address areas for improvement were not always documented.

Staff were aware of their roles and responsibilities.

Woodside Nursing and Residential 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.

This inspection took place on 23 February 2016 and 16 March 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people and the provision of care to older people in a care home.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with a healthcare professional who was visiting the home during our inspection, six people and three friends or relatives of people who lived at the home. We also spoke with two care staff, the chef, the Registered Manager and one of the Directors of the provider company.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for four people. We also looked at how people's medicines were managed. We looked at two staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

People told us that their medicines and the reasons they had been prescribed were discussed with them. One person told us, "I have been having this medication and we're sticking to it." During this inspection we found that people did not receive their medicines as they had been prescribed. Medicines were administered only by trained nurses. On the day of our inspection the nurse on duty was on the bank staff and worked at the home as and when needed. We looked at the medicines administration records (MAR) for five people and found that there were a number of unexplained gaps in the records of three people. The manager could not explain why these gaps had occurred and could not be certain that people had received their medicines. We noted that one person had been prescribed medicine that was to be given 30 minutes before they ate their breakfast. We spoke with the nurse who told us that the medicine was given in the morning round after the person had eaten their breakfast. This meant that the medicine was not effective for the individual. We checked if the stocks of medicines held for two people were as their records indicated. We found that, even though it was only the second day of the monthly cycle, there was a difference between the stock held of one medicine with that the records indicated. We brought this to the attention of the manager who said they would discuss this with the nurse on duty.

Medicines were normally stored in a locked trolley in the nurses station on the first floor. However, we noted that thickener that had been prescribed for use in drinks provided for one person had been left on a mantelpiece in one of the lounge areas. This meant that people could have accessed it inappropriately.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

Prior to the inspection we had received concerning information about the cleanliness of the home and unhygienic practice by the staff. During this inspection we found that people were not cared for in a clean and safe environment. One person told us, "I always hear that my room is very untidy and unkempt. It's not my responsibility." A relative told us, "Sometimes it does smell." A friend of one person told us that they had seen used continence products left on a chair in one person's room instead of being disposed of immediately. This left the person at increased risk of infection and a risk of contamination of the chair.

On our arrival we did not immediately notice any unpleasant odours but on a walk around the home we identified that there were improvements required with both the standard of cleaning and the maintenance of the facilities. We noted that three of the four toilets at the home were not fully operational during our walk around. In addition the bathroom on the first floor was very dirty, as was the shower room. The Registered Manager immediately contacted the provider's maintenance service who attended the home and rectified the faults with the three toilets. When we returned to the service we found that toilets had been replaced and all were fully operational. In addition the walls of two of them had been re-tiled and the Registered Manager told us that arrangements were in place for the bathrooms to be refurbished. The shower room had been steam cleaned and a new shower curtain was in place.

We looked in a number of bedrooms and found that these had not been cleaned thoroughly and that paint

work around some of the windows was chipped, dirty with evidence of mould growth. The paintwork in corridors, walls, doors, handrails and radiator covers had been damaged in areas and not cleaned effectively. Some hand rails were very dusty as were the decorative radiator covers. Whilst we were there the Director had arranged for their maintenance service to repaint some areas that had recently been damaged by water and the Registered Manager told us of plans to refurbish the property. The Registered Manager and the Director told us that they had recruited a new cleaner who was in their induction period at our initial visit and had assumed full duties from 07 March 2016. When we returned to the home we noted that there was a significant improvement in the standard of cleanliness around the home and the cleaner had introduced a detailed cleaning schedule which made provision for each bedroom to be deep cleaned once every two weeks. The schedule also included provision of high level dusting in rooms and corridors. The Director was confident that the new cleaner would be able to maintain an acceptable standard of cleanliness around the home.

We had noted that there were areas in the kitchen that were dirty, particularly around the external door and wire trunking near it. We noted that there was damage to some of the cupboard doors and the food preparation surface. We also noted that paintwork within the kitchen and the internal door was chipped. This meant that these could not be cleaned effectively and put people at risk of infection. When we returned we noted that the kitchen had been deep cleaned but the cupboard door and food preparation surface were still damaged and could not be cleaned effectively.

We saw that people ate their meals on sanded wooden table tops. These were neither polished nor painted. The Director told us that the tables were covered with fresh table cloths when people ate at them. However, we saw people eat their breakfast and later their lunch at the tables with no cloths on them. One person was observed to push their food from their plate and eat it from the table. The table was stained with marks from mugs and food. Small tables in one of the lounge areas, also used by people to eat their food, were seen to be chipped and unable to be cleaned effectively. This put people at risk of infection. The Registered Manager told us of plans to replace the tables in the dining room and new tables had been provided in the lounge area for people to use to eat their meals.

People told us that they felt safe at the home for a number of reasons. One person said it was, "The general sort of set up, people being around to help." Another person told us, "There's plenty of doors. Nobody can get in from the outside. There's somebody near enough to each door that opens to the outside." A third person said, "I moved in here and I've felt quite secure here ever since I've been here. There's been nothing to make me feel otherwise." However, a visitor to the home did not believe that people were always safe at the home. They were not satisfied that care was always provided in a safe way, particularly when people ate their meals whilst in bed. Over the bed tables were not always available or at a suitable height. We saw one person resting a plate that held their lunch on their chest whilst they ate their meal as the table was at an inappropriate height due to bedrails. They were exposed to unnecessary risk of harm as they could have suffered burns to their chest had the plate or the food been hot.

The Registered Manager told us that closed circuit television (CCTV) had recently been installed for security reasons and to monitor areas such as the lounges and corridors to keep people safe. Should someone who needed assistance in walking be seen attempting to walk unaided in the areas monitored the Registered Manager could take appropriate action to keep the person safe and prevent them from falling. One person told us, "They won't let me walk on my own. Someone always walks behind me."

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the home. Staff told us that they had been

trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I have referred matters to the safeguarding team in previous places but not here." They also told us what actions they would take if they had concerns about people's safety and wellbeing. Staff also said that they were aware of and understood the provider's whistleblowing policy and would not hesitate to use it.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with the use of bed rails. However, we noted that the risk assessment in respect of the bed management system in one care record we looked at was incomplete and it was unclear as to why the decision that bed rails were needed had been made. We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of both of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and by talking at shift handovers. This gave staff up to date information and enabled them to reduce the risk of people suffering harm.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included assessments of any hazardous substances on the premises, fire risk assessments and the checking of portable electrical equipment. We noted that a recent inspection by the Bedfordshire Fire and Rescue service had identified actions that were needed to keep people safe in the event of a fire, including some repairs to the fabric of the building and the purchase of evacuation aids for people who lived on the first floor and required assistance to use the stairs. The Registered Manager told us that the repairs had been completed and the evacuation aids had been ordered. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained with it remained current. These enabled staff to know how to keep people safe should an emergency occur.

People had mixed opinions as whether there were enough staff to support them effectively at all times. Some people felt there were enough staff to support them. However, one person said, "If we had a full complement of people, there would be somebody here to call to our attention." Another person said, "I think there's not enough staff to do the job with ease. It's a hard job for them and they could do with help." People told us that when they used their call bell to request assistance staff responded quickly which would indicate that there were enough staff to support people appropriately. We saw that when a call bell was activated staff responded to it within five minutes. However, when an alarm bell was activated during our inspection staff responded to it immediately.

In addition to the staff employed by the home the Registered Manager had forged links with local colleges and students regularly completed work experience placements at the home. During our inspection two students were completing a two week placement and the Registered Manager told us of another student who was completing an eight week placement with them. Volunteers from local societies, such as the Horticultural Society, also assisted at the home. Relevant checks had been completed before students and volunteers worked with the people who lived at the home.

We looked at the recruitment documentation for two members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written

references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the skills that were required to care for them. One person said, "I've got enough confidence in the staff that if I needed to ask anyone to do anything I could do that." Another person told us, "It seems to be run quite efficiently and painlessly for the occupants. I would say it's pretty alright that way." A relative said, "Most of the staff know what they are doing most of the time."

Staff told us that they received the training they required for their roles. Training was normally completed as distance learning and evaluated by an external assessor by way of a written test. When staff achieved the pass mark they were issued with a certificate, which was valid for a period of three years. One member of staff told us, "[Registered Manager] has the certificates. [They] say when it expires and get all the packs for us. We can do them when we are here but I prefer to do them at home. They went on to explain how the training they had received in end of life care had made them more vigilant in looking for changes in people's health. A healthcare professional told us that they had delivered face to face training on swallowing difficulties for staff and had noticed an increased awareness of this by staff after the training. We saw that staff were supported to study for nationally recognised qualifications in health and social care. An assessor was evaluating the work of two of the care workers during our inspection.

Staff also told us that they received regular supervision at which they were able to ask questions, discuss any problems, agree goals for their development and discuss any training they wanted. They said they felt supported in their roles and were supported to study for health and social care qualifications. This meant that they were supported to enable them to provide care to a good standard.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that, where applicable, assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest. We saw that one care record we looked at contained an authorisation from the relevant supervisory body to deprive a person of their liberty in order to keep them safe. We noted that another care record included information that a relative had Power of Attorney to make decisions affecting their health and welfare and saw that the documentation regarding this was held securely by the manager.

People told us that staff asked for permission before they supported them. One person said, "They respect

the fact that you can do things for yourself." Another person told us, "If I want as bath, I have a bath. They never do [anything] against my will." Staff told us that they always asked for people's consent before providing any care or support. One member of staff said, "You go in and ask if they are happy for you to carry out their personal care. While you are giving it you explain exactly what you are going to do and make sure they are happy with it." However, we saw no evidence that people had given their consent to be monitored in the corridors and lounge areas by the closed circuit television.

People had mixed opinions about the food and drink they received. One person told us, "I've never had to turn any food away. It's always been very palatable." Another person told us, "It's pretty good." However, a third person said, "None of it would be to my taste and, if there is a taste, I can't taste it." We observed the lunch time experience for people who lived at the home. The tables in the dining room were bare and people were given their cutlery when they were given their meal. There were no drinks or condiments on the tables but people were offered a choice of juices with their meal. The meal served at lunch time looked quite appetising. Where someone was unable to eat solid food, it had been cut up very finely rather than pureed, so still had some texture. People who required assistance were supported to eat their meal and staff conversed with them as they assisted them to eat. We saw that one person refused the assistance they were offered and in their attempt to eat their meal unaided they pushed the food from the plate and ate it from the table top. A member of staff who noticed this cut their food up and gave them a spoon so that they could eat it more easily.

The chef told us that a choice of meals was offered for breakfast and tea. Although a choice was not offered for lunch, people could have an alternative such as an omelette or jacket potato if they wanted. The chef also said that people did not have to have the main meal at lunch time if they preferred to have it in the evening. The chef was advised by the care staff of people's special dietary needs. One staff member told us, "We usually know what they were used to eating when they first come in. Some people only want small meals and might prefer a sandwich to a main meal. If they have dementia we work out what they used to prefer by talking with their families. If they are not eating we try to find out why." People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake that provided detailed information on what they had consumed. Where needed, referrals had been made to the local dietetic service and the speech and language therapists. One healthcare professional told us that concerns were raised with them very quickly.

People told us that they were supported to maintain their health and well being. Staff supported people to attend health appointments. One person told us that staff had accompanied them to both the dentist and a hospital appointment. Records showed that referrals to other healthcare professionals had been made on people's behalf. These had included Speech and Language therapists, Occupational Therapists, a Tissue Viability Nurse as well as GP's and District Nurses. A chiropodist visited the home every six weeks.

Good

Is the service caring?

Our findings

People and the relatives we spoke with told us that the staff were kind and considerate. One person told us, "The girls are very helpful." Another person said, "They're nice girls." A third person told us, They've always been supportive and helpful." A relative said, "They are very good to [relative]. [They] are happy here."

People told us that staff talked with them about their past histories. One person said, "They write notes about me." Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives, and from the lifestyle profiles within people's care records, which included a 'This is me' section. The lifestyle profiles had been developed in discussion with the people and their relatives to give as full a picture of the person as possible. This information enabled staff to provide care in a way appropriate to the person.

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. We saw that staff communicated appropriately with people. They were laughing and joking with people as well as talking with them in a gentle and caring way. A visitor told us, "[Person]'s got to know all the carers and they have their banter." They went on to say, "Carers will always give [them] a hug and have a little talk with [them]. Another visitor told us, "The carers seem to be good at engaging with people. They're kind."

We noted that staff promoted people's dignity. People in the communal areas appeared to be clean and well dressed. When a member of staff noted that a person's clothing required adjusting to cover their underwear they asked for the person's permission and made the necessary adjustment. In doing so they noticed that the person's jumper had been soiled and arranged for it to be replaced with a clean jumper. On our walk around the home we saw one person lying on their bed with the door to their room open. They were wearing only a top and underwear. The Registered Manager asked them, "Would you mind being covered up or can I get you a sheet?" We later saw that they were covered and their dignity restored. Staff members were able to describe ways in which people's dignity was preserved. For example asking quietly if they require personal care in communal areas, ensuring that doors and curtains were closed when providing personal care and covering people when helping them to wash. Staff explained that all information held about people was confidential and would not be discussed outside of the home to protect people's privacy. One staff member told us, "Everything that goes on in the unit is confidential but if a service user was at risk of harm I would act on it."

People told us that they were involved in determining how their care was delivered. One person told us, "They take things out of the wardrobe and ask me if I want to wear it." Another person said they wake up on their own at 5.30am and then somebody comes in to see them. They went on to say they chose to have breakfast in their room. They said, "I sit in the chair and have breakfast in my room as I want."

People were encouraged to be as independent as possible. One person told us, "I think I can do most things." Another person said, "I'm fully able to get round with my frame." We saw a member of staff explain

to someone how they should transfer from a wheelchair to a chair and encouraged them to do it. Staff told us of ways in which people were encouraged to maintain their independence. One member of staff told us, "When giving personal care we will give people a flannel so they can help to wash. If people can feed themselves we let them do it even if we have to clean up after them. If someone can walk a few steps we let them."

Friends and relatives were able to visit people whenever they wished. One relative told us, "I can come at any time. I usually come about 11 in the morning every day."

People told us that they received all the information they needed. One person told us, "Everything we need and need to know is on tap. I would have no qualms about asking. It's not the sort of place you couldn't ask about something." We saw that there was information displayed within the reception area about the home and services available within it, including a weekly hairdresser and a chiropody service. Information about weekly visits by a Pet as Therapy (PAT) dog was displayed as well as information on safeguarding and the provider's complaints system, together with an advice leaflet produced by the local council. This provided people and the relatives contact details they might use if they wanted advice or to raise any concerns outside of the home. There was also information on meals and activities on the wall in one of the communal areas.

Requires Improvement

Is the service responsive?

Our findings

One relative told us that they had been consulted and had agreed care plans on their relative's behalf. They said, "I have not got Power of Attorney over health and welfare but they let me know about any changes. They would consult me first. I have signed care plans." However, of the four care records we looked at three had no evidence to show that people or their relatives had been involved in the assessment of their needs or the development of the care plans. One person had entered the home for a period of respite care and had decided to stay. We saw that admission protocols were in place which detailed the actions required in the first 72 hours following admission to the home which included an assessment of their personal care needs on admission and an assessment of their mental capacity to make decisions on their own behalf. We saw that care plans had been developed within the time frame set but consent for these had not been signed. One care plan for a person admitted to the home in November 2015 was incomplete with the care plan for lifestyle and interests and the person's life history section being blank. Although this person had been judged to have the mental capacity to make their own decisions regarding their care needs there was no evidence that they had been involved in the development of their care plans. They had not signed them to say they had agreed them and consent for the use of their photograph had been signed by the Registered Manager.

We noted that although there was evidence that care plans had been reviewed on a monthly basis the care plans had not been updated when people's assessed needs had changed. For example there was a care plan in one record which had been produced when the person had moved into the home in November 2015 for percutaneous endoscopic gastrostomy (PEG) feeding. Although the care record included a letter received in February 2016 to state that the PEG feed was no longer required the care plan still indicated that the person should continue to be given a PEG feed in the evening. The Registered Manager told us that the PEG feed was no longer administered but a member of staff new to the home would not know this from the care plan. A second care record included a care plan for skin integrity. This had been reviewed on 04 February 2016 but had not been updated when an awaited response had been received on 10 February 2016 and required the plan to be amended. The care plan had been reviewed at the regular monthly review held on 11 March 2016. Within the care record for this person was a wound management profile that required dressings to be changed twice a week on Monday and Thursday. There was no record to show that the dressings had been changed on the Monday prior to our inspection. We saw that the care plan relevant to moving and handling for one person had however, been amended that day when the person had been assessed as requiring the use of a hoist for transfers from bed and chairs at the staff handover.

The care staff told us that the care plans were reviewed by the nursing staff. We saw that people were involved in the monthly review of their care plans with the nurse. On the day of our inspection we saw the nurse sitting with one person and reviewing the care plans with them. During this review they discussed the person's likes and dislikes as well as the medicines that they were taking. This ensured that at the date of the review the care plans reflected the person's assessed needs and the way in which they wished to be supported with these. However, the person was living with dementia and the review took place before the person's relative arrived, even though they visited the home on a daily basis. The relative was therefore unable to participate in the review and the person living with dementia had difficulty in retaining the

information.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on the level of activity that was provided. One person said that they get up, chat with friends and watch TV. They said, "It's like a home from home. I'm happy." Another person said, "I have the television and read books." A visitor told us, "I haven't seen any activities or any attempt to pick up on [person's] interests." However a relative said, "There are good activities. Yesterday they were playing farmyard dominoes. They talk to each other. They are trying to get [relative] to do some drawing. There are so many people to cater for." One member of staff told us that they involved people in activities after they had eaten their tea. They told us, "Yesterday it was cards." We saw that a Pets As Therapy (PAT) dog attended the home every week. The Registered Manager told us that people really enjoyed these visits. In addition they said that a lay preacher from the local church came in to sings hymns once a month and a number of volunteers also supported people at the home on a regular basis. We saw that the volunteers had worked in the garden area and made scarecrows with people in the autumn. The Registered Manager told us that they had plans in place to build a poly-tunnel in the garden so that people could be involved in growing fruit and flowers. They also told us that the provider had accepted that additional resources were required to support people with their interests and hobbies and the former cleaner had taken over the role of activities coordinator. They were booked to receive training from a nationally recognised organisation for activities with people who live with dementia to support them in their new role. We saw that activity logs had been introduced to evidence how people had spent their time. These included information about people's interests and hobbies so that suitable activities could be offered to them.

People and relatives were aware of the provider's complaints system. Information about this was on display in the entrance hall of the home. One person said, "I've never had any complaints." Another person told us, "I'd tell them I wasn't happy about it." One relative told us that the Registered Manager listened when they raised matters with them. They said, "They had been putting on the thinner cardigans and I had not seen the thicker jumpers I bought so I asked where they were. [Relative] was wearing a thicker one yesterday."

People told us that they were not routinely asked for their opinions on the service. One person said, "As long as you come here and find people that are as happy as I am with the place [there is no problem]." However, we saw evidence that the Registered Manager had carried out a satisfaction survey with people and relatives in October 2015. Seven forms had been returned, all of which had been positive about the care provided.

Requires Improvement

Is the service well-led?

Our findings

There was a quality assurance system in place that covered areas such as medication, infection control, hand hygiene and health and safety. The Registered Manager carried out monthly audits around the home. However, where areas for improvement had been identified, such as bathrooms not being clean and there being clinical waste in the toilets no action plan had been developed to monitor how these were addressed. The Registered Manager told us that they took the appropriate action and followed it up at the next monthly audit, although there was nothing to evidence this and similar areas of improvement had been identified at each audit. We did see evidence that where an audit had been completed by an external organisation, such as the Fire and Rescue Service, the Registered Manager had developed an action plan to address the areas for improvement that had been identified.

We noted that there was no regular check of the care records. The Registered Manager told us that they would normally carry out a visual check of each care record but there was no formal recording of these checks. However, the care records we looked at would indicate that no check had been made to ensure that they had been completed to an acceptable standard or updated when this was appropriate. We had brought to the Registered Manager's attention, on the first day of our inspection, that two of the care plans we looked at required updating to reflect changes in the person's requirements. However, we noted that one had still not been updated when we returned to complete the inspection and the second had been updated only at the monthly review. The Registered Manager explained that they had been unable to carry out regular checks of the care records for some months. They were therefore unaware of the quality of the documentation.

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

People told us that they knew who the Registered Manager was and that they saw them regularly. One person told us, "She was here with us this morning as she was passing through. We see her maybe once a day, maybe every other day. She stopped this morning and had a chat." A relative said, "[Name] has sat and had coffee with us, although this has not happened often."

We noted that the last meeting held with people and their relatives to discuss the service provided and any changes or improvements that people may want was in November 2014. The Registered Manager told us that people and relatives did not want these meetings and instead they had introduced an 'open door' policy and people or relatives could talk to them at any time. During the inspection we observed relatives of people talking to the Registered Manager in their office. The manager had also recently put in place a system of recording queries and comments in a book as they occurred which they told us they would use to identify any suggestions for improvements to the service. We noted from the satisfaction survey that people and relatives were asked what they would want to change about the service provided. Suggestions made had been for improvements to the laundry and parking. The Registered Manager told us that the provider had submitted plans to expand and improve the home which included a new laundry facility and improved parking.

Minutes of staff meetings showed that staff had been encouraged to contribute to identifying improvements that could be made to the service. Topics covered at meetings had included policies and procedures, training and the introduction of closed-circuit television (CCTV). Staff we spoke with were aware of their roles and responsibilities. They explained that they provided care in a way that was people-centred and promoted people's independence.

Care records were kept securely in the nurse's station which was locked when unoccupied. This meant that the records could only be accessed by people authorised to do so.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not given their medicines as they had been prescribed. Medicines administration charts were not completed correctly and the stock of medicines held did not reconcile with that shown on the records. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans were not updated other than at the regular monthly review. This meant that they did not reflect advice provided by healthcare professionals. Regulation 17(2)(c) The quality assurance system in place was weak and there were no plans in place to monitor actions required in respect of identified areas for improvement Regulation 17 (2)(a)