

Leonard Cheshire Disability

Kenmore - Care Home with Nursing Physical Disabilities

Inspection report

Kenmore
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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We inspected Kenmore - Care Home with Nursing Physical Disabilities on 12 October 2016. This was an unannounced inspection, which meant that the staff and registered provider did not know we would be visiting. When we inspected the service in November 2013 a breach of legal requirements was found. We had found that appropriate arrangements were not in place for the management of medicines. A pharmacist inspector visited again in May 2014 to check whether improvements had been made. At the inspection in May 2014 we found that the registered provider had followed their action plan and appropriate arrangements were in place for the management of medicines.

The home had a 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.

Kenmore provides both accommodation and nursing care for up to 26 people who have physical disabilities. People who use the service are usually between the ages of 18 and 65. People aged over 65 are not routinely admitted to the service but there may be cases dependent on the person's medical condition or needs when this would be appropriate. Kenmore is considered a home for life so people may stay as long as their needs can be met. The home is a detached Victorian house set in its own grounds extended to provide single room accommodation on the ground and first floor. At the time of the inspection there were 26 people who used the service.

The service did not have systems in place to make sure people received their medicines as prescribed. Written guidance for 'as required' medicines was not available and staff did not always take the daily temperature of the room and fridge where medicines were stored. The registered manager told us any medicine errors were fully investigated, however records were not available during the inspection to confirm this.

One person and a relative told us dignity had been compromised on occasions with staff arriving too late to provide personal care. We pointed this out to the registered manager at the time of the visit who told us they would discuss our concerns with staff immediately to make a positive difference.

Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety. However, the testing of water temperatures was not planned to make sure baths, showers and sinks were tested at the same frequency.

Risk to people's safety had been assessed by staff and these included risks with moving and handling, nutrition, falls, the use of specialist equipment and risks associated with personal care. Some risk assessments were better than others and detailed preventative measures to keep people safe. However,

some risk assessments contained limited information. This meant staff did not always have detailed written guidance to help keep the person safe. We noted that there were some gaps in the reviewing of risk assessments.

The registered manager told us that staffing levels were reviewed on a regular basis to ensure people's needs were met. We didn't see any examples during the inspection of people being kept waiting and call bells were generally answered within three to four minutes.

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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People subject to DoLS had this recorded in their care records. However, mental capacity assessments were not decision specific. Best interest decisions were not recorded in care plans.

Staff had not received regular supervision or an annual appraisal. Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people who used the service. Staff told us they received mandatory training and other training specific to their role. Training records were held centrally by the registered providers learning and development department. There was an online HUB where staff training was recorded but we were told that updates to this take many weeks and sometimes months which always makes training statistics appear low. Reports of training we were provided with showed training was out of date for many staff, however the registered manager provided reassurance that all staff were up to date with their training it was the training statistics that were inaccurate.

Care records were insufficiently detailed to enable staff to provide safe care and treatment. Care records had not been reviewed and updated on a regular basis. Care records contained some information about the person's likes, dislikes and personal choices, however some were task orientated and did not contain sufficient detail to be person centred.

Quality monitoring was ineffective and did not pick up on the issues we found at this inspection. Staff meetings were infrequent.

People were protected by the services approach to safeguarding and whistle blowing. People who used the service told us they felt safe and could tell staff if they were unhappy. People who used the service told us that staff treated them well and they were happy with the care and service received. Staff were aware of safeguarding procedures, could describe what they would do if they thought somebody was being mistreated and said that management acted appropriately to any concerns brought to their attention.

We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show staff employed were safe to work with vulnerable people.

We saw that people were provided with a choice of healthy food and drinks, which helped to ensure that their nutritional needs were met. The service had achieved Kirklees Healthy Choice Award from Kirklees Council (gold standard) which acknowledges good standards of hygiene and places that offer healthy eating options.

People were supported to maintain good health and had access to healthcare professionals and services. People were supported and encouraged to have regular health checks and were accompanied by staff to

hospital appointments.

There were positive interactions between people and staff. Staff were attentive and interacted well with people. Observation of the staff showed that they knew the people very well and could anticipate their needs. People told us that they were happy and felt very well cared for.

People's independence was encouraged. Activities, outings and social occasions were organised for people who used the service.

The registered provider had a system in place for responding to people's concerns and complaints. People told us they knew how to complain and felt confident 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 took 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.

Systems were not in place to make sure people received their medicines as prescribed.

Staff were aware of the different types of abuse and what would constitute poor practice. Staff knew how to recognise and respond to abuse correctly.

Staffing levels were regularly reviewed to ensure there were enough staff on duty to meet people's needs. Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work.

Checks of the building and maintenance systems were undertaken, but these were not always consistent

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff had an understanding of the Mental Capacity Act (MCA) 2005; however MCA assessments were not decision specific. Best interest decisions were not recorded within care plans.

Staff had not received regular supervision or an appraisal. Staff had the knowledge and skills to support people who used the service, however training records were not up to date.

People were supported to maintain a healthy diet and to access external healthcare professionals.

Is the service caring?

Requires Improvement ●

This service was not always caring.

People's dignity was compromised on occasions with staff arriving too late to provide their personal care.

Staff took time to speak with people and to engage positively with them.

People had access to advocacy services. This enabled others who to speak up on their behalf.

Is the service responsive?

The service was not always responsive.

People's needs were assessed and care plans were produced however, these were not always person centred. Care records were not always reviewed and updated regularly.

People were involved in a range of activities and outings.

People and relatives were aware of how to make a complaint or raise a concern. They were confident their concerns would be dealt with effectively and in a timely way.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Quality monitoring was ineffective and did not pick up on the areas of concerns that we identified during the inspection.

The majority of people and their relatives spoke highly of the registered manager and staff.

Meetings for people who used the service and relatives took place to keep people informed and to encourage people to share their views.

Requires Improvement ●

Kenmore - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

We inspected the service on 12 October 2016. This was an unannounced inspection, which meant that the staff and registered provider did not know that we would be visiting. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. The registered provider had completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We sat in communal areas and observed how staff interacted with people. We spoke with seven people who used the service and four relatives. We looked at communal areas of the home and some bedrooms.

During the visit we spoke with the registered manager, the care manager, a nurse, the volunteer co-ordinator, the activity co-ordinator, a volunteer, a senior care assistant and generally to care staff. We also contacted commissioners of the service and Healthwatch Kirklees to seek their views. They did not inform us of any concerns.

During the inspection we reviewed a range of records. This included four people's care records, including care planning documentation and medicine records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the registered provider.

Is the service safe?

Our findings

We looked at the arrangements in place to ensure the safe management, storage and administration of medicines. We saw that medicines were stored securely.

Nursing staff were able to describe the arrangements in place for the ordering and disposal of medicines. Each month nurses completed a stock check of medicines and ordered what was needed for each person for the month ahead. We were told that medicines were delivered to the home by the pharmacy usually about three days before their current supply of medicines ran out. Medicines were checked in by nurses to make sure they were correct. Nurses told us by having the medicines delivered three days early this ensured continuity of supply and enabled them to rectify any incorrect prescriptions. Records of ordering and disposal of medicines were kept in an appropriate manner.

Room temperatures were monitored to ensure that medicines were stored within the recommended temperature ranges. Temperatures of the fridge used to store medicines requiring cool storage were also kept and were within recommended ranges. However, we did see some gaps in recording. We pointed this out to the registered manager at the time of our visit who told us they would take action to address this.

People were prescribed medicines on an 'as required' basis, however 'as required' guidelines had not been written for these. 'As required' medicines were written up on the person's medication administration record but a specific plan was not in place. This meant that staff may not have clear guidance and instruction on when to administer these. The registered manager told us they would take immediate action and implement such guidelines.

We checked records of medicines against the stocks held and found that the majority of these balanced. However, records indicated one person had not been administered their pain relieving patch as prescribed. The pain relieving patch was to be applied every four days but records indicated that the person may have gone five days without this being changed. We asked the registered manager to look at this and if the person had gone without their pain relieving patch make a safeguarding alert to the local authority. We received confirmation after the inspection that the registered manager had raised a safeguarding alert and in addition opened up the registered providers complaint procedure. A meeting was held with nurses to discuss medicine concerns and our findings and we were told that nurses would have their competency with the administration of medicines reassessed.

Examination of staff records during the inspection identified two further medicine errors. We asked the registered manager and care manager what action was taken following the errors and we were told that a full investigation was conducted and staff interviewed. We asked to see the records relating to both investigations but they could not be found.

This meant medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and relatives if there were enough staff on duty to meet people's needs. One person said, "I think there are enough." Another person said, "Whenever I need them [staff] they are there for me." Another person said, "There can never be enough staff we [people who used the service] always need more." A relative said, "I couldn't tell you about the night time as I do not visit then, but I have not seen staff struggle during the day." Another relative we spoke with said, "I think the care is fantastic and the carers themselves are great but there is never enough staff. [Name of one of the nurses] is always telling us there isn't enough staff and we will have to wait." Another relative said, "Staff are always busy it wouldn't harm to have more staff on duty."

We did not see any examples during the inspection of people being kept waiting and call bells were generally answered within three to four minutes. The registered manager told us they constantly reviewed staffing levels to ensure people's needs were met. The registered provider told us they aimed to respond to all calls in a timely manner and that staff worked very hard to achieve this, however inevitably and unavoidably during periods of peak activity such as early in the mornings there may be occasions when all staff will be busy supporting people with personal care and people may have to wait a little longer than is usual for staff assistance.

The call system was linked to a computer in the nurse's office to monitor call response times. The registered provider told us the average response time was around three to four minutes. The registered provider told us to prevent anyone having to wait unduly their call system automatically switched to emergency mode after six minutes if not answered in order to alert staff that someone had been waiting and/or may be in difficulty. We were told this was a rare occasion for the call system to switch to emergency mode.

Care plans we looked at incorporated a series of risk assessments. They included areas such as the risks around moving and handling, nutrition, falls, the use of specialist equipment and risks associated with personal care. Some risk assessments were better than others. For example, the risk assessment for one person for movement and mobility detailed that staff should walk either side of the person and the person should wear protective head wear to prevent injury. This meant staff had the written guidance to help keep the person safe. However, another risk assessment was in place informing the person should use a waist belt when sitting in their wheelchair. The risk assessment did not detail the risks associated with the use of a waist belt and how to ensure the person's safety. We noted that there were some gaps in the reviewing of risk assessments, for example the falls risk assessment for one person had been reviewed in April 2016 but then not again until September 2016. We pointed this out to the registered manager who told us they would ask nursing staff to review and update everyone's risk assessments.

We asked people who used the service about safety. One person told us, "Yes the security is good and I have always felt safe." Another person said, "The place is very safe."

Staff we spoke with during the inspection were aware of the different types of abuse and what would constitute poor practice. Staff told us they had completed training in safeguarding and were able to describe how they would recognise any signs of abuse or issues which would give them concerns. They were able to state what they would do and who they would report any concerns to. The service had safeguarding policies and procedures in place for recognising and dealing with abuse. Staff said they would feel confident to whistle-blow (telling someone) if they saw something they were concerned about.

We saw robust recruitment and selection processes were in place. We looked at the files for four of the most recent staff to be employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had

also been obtained. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with children and vulnerable adults.

During the inspection we spoke with the volunteer co-ordinator who told us the same robust recruitment checks were undertaken on all volunteers as those staff who were employed. We also spoke with a volunteer who confirmed this.

We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the gas safety, fire extinguishers, emergency lighting and the fire alarm. This showed that the registered provider had developed appropriate maintenance systems to protect people who used the service against the risks of unsafe or unsuitable premises and equipment.

We also saw that personal emergency evacuation plans (PEEP's) were in place for each of the people who used the service. PEEP's provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. Records showed that staff had taken part in evacuation practices. We saw records to confirm that the fire alarm was tested on a weekly basis to make sure it was in working order.

Water temperatures of baths, showers and sinks were taken to make sure they were in safe limits. However, we did note that there was no system in place to ensure every outlet was tested at the same frequency. The registered manager told us they would speak with the handyman in respect of this as they were responsible for the testing of water temperatures.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. We saw that analysis was undertaken on all accidents and incidents in order to identify any patterns or trends and put measures put in place to avoid re-occurrence.

Is the service effective?

Our findings

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection seven people were subject to DoLS authorisations with a further five awaiting authorisation. People subject to DoLS had this recorded in their care records and the service maintained an audit of people subject to a DoLS so they knew when they were to expire.

The registered manager told us that some people who used the service lacked capacity to be involved in their care planning process and all decisions surrounding their care and needs were to be made by staff, family and other professionals. However, people's care records did not contain decision specific mental capacity assessments and best interest decisions were not recorded within care plans. We pointed this out to the registered manager at the time of the inspection who told us they would commence work on capacity assessments as a matter of importance.

Throughout the inspection we saw examples of staff making decisions that were clearly in the best interests of people they knew well, for example supporting people with their personal care and assisting with eating and drinking. Our judgment was that staff did act in the best interest of the people they supported but that processes had not been followed to formally assess and record this.

This meant that staff did not always work within the principles of the MCA 2005. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider's policy stated that staff should have three supervision sessions a year and one annual appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Records examined and discussions with the registered manager and staff identified that staff had not consistently received supervision. The registered manager acknowledged they were behind with supervisions. They told us that staff had been unsure of the supervision process and that they had delivered four training sessions themselves and that formal training was also due to be delivered by the registered provider. We were told, "Some appraisals are a couple of years out of date. Some supervisions haven't been done for a year. The documentation has changed so people are struggling. We often have informal discussions and I do have contact with staff. Staff come to me with any issues but we just don't formalise it."

We were shown the filing cabinet where the supervision records were held and looked at a number of staff files that were picked out at random. The records we looked at indicated that some staff had not received supervision sessions since 2009 and 2012. We were told by the registered manager that more recent supervisions had taken place but the records of these could not be produced. The system was not well organised, with documents kept in a variety of places and overseen by a number of different staff meaning there was no accurate overview of records or one place to find all of the necessary information.

We saw evidence that annual appraisals had begun to take place and we were told that the plan was to ensure all staff had an up to date appraisal and then begin a programme of regular appraisals.

One member of staff we spoke to told us, "I couldn't tell you the last time I had supervision. I have been here for eight years and I have only had one appraisal. I have maybe had two or three supervisions."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service who told us that staff provided a good quality of care. One person said, "I like living here very much. I have a good life and all the staff are really great." Another person said, "I get all the help I need from very nice staff." A relative we spoke with said, "Staff are kind and very caring, very nice people. I think they [people who used the service] are in the right place because of the attitude of the staff. That is more important to me than doing everything by the book. They are all very approachable."

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people who used the service. Staff told us they received mandatory training and other training specific to their role. Staff had undertaken training considered to be mandatory by the service including safeguarding vulnerable adults, fire, health and safety, nutrition, medicines administration, and behaviour support awareness. Training records were held centrally by the registered providers learning and development department. There was an online HUB where staff training was recorded but we were told that updates to this take many weeks and sometimes months which always makes their training statistics appear low. Reports of training we were provided with showed training was out of date for many staff, however the registered manager provided reassurance that all staff were up to date with their training it was the training statistics that were inaccurate.

People were supported to maintain a healthy diet. We looked at the home's menu plan. The menus provided a varied selection of meals. We saw that other alternatives were available at each meal time such as a sandwich, soup or salad. The service has achieved Kirklees Healthy Choice Award from Kirklees Council (gold standard) which acknowledges good standards of hygiene and places that offer healthy eating options.

We observed the lunch time of people who used the service. We saw that lunchtime was a sociable event with staff and people who used the service interacting with each other. The relative of one person visited every lunchtime and we saw that they socialised with people who used the service. Another relative also visited and supported the person who used the service to eat their lunch. Some people were provided with clothes protectors which enabled people to eat independently without staining their clothes. The atmosphere was relaxed with people seen to enjoy their lunch.

To aid independence there was a fridge and kitchen area which was accessible to people who used the service. During the inspection we saw people access the fridge to take out sauce bottles and the freezer to

help themselves to ice-cream. Tea and coffee was prepared in flasks and those people who were able helped themselves.

Some people needed help to cut up their food and others needed assistance to eat. We observed staff helping people to eat and saw they were given small mouthfuls and given enough time to eat their food before the next mouthful. Staff respectfully spoke with people and provided them with drinks. People told us they enjoyed their lunch. One person said, "I have a good appetite and enjoy my food." People confirmed they got the help they needed at meal time. One person said, "They help me cut up my food." Another person said, "I sometimes go into the dining room but not often as I like the quiet of my room. The food is very good and I can't knock it. I like to keep my meals in my fridge and they will microwave them for me. They will do what they can for me in the kitchen.

The cook was involved with any assessments done by the speech and language therapy (SALT) team to check on people's swallowing abilities. They kept information relating to people's dietary requirements within the kitchen for easy reference and demonstrated a good knowledge of people's nutritional needs and how best to meet them.

The registered manager told us that all people who used the service had undergone nutritional screening to identify if they were malnourished, at risk of malnutrition or obesity. The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening people are weighed at regular intervals and depending on the risk appropriate action was taken to support people who had been assessed as being at risk of malnutrition.

We saw records to confirm that people had received visits from the dentist, optician, chiropodist, dietician and their doctor. However, the oral health check form for one person merely stated 'no teeth' however oral health checks look at the health of the mouth in general not specifically the teeth. We could not be sure that this person was receiving the correct support to access all necessary health checks. We pointed this out to the registered manager who told us the person did not routinely see the dentist as this caused some distress, however staff checked their mouth on a regular basis and observed for any signs of distress and if needed the GP would be contacted for advice.

Staff told us they had good relationships with the doctors who visited people. Staff told us the doctors would visit at any time if needed. People were accompanied to hospital appointments by staff, however if relatives preferred to support the person they were able to. Relatives told us staff acted quickly when people became unwell and kept them up to date with the outcome of any doctor or hospital visits. One relative said, "As soon as [person who used the service] is unwell they are onto it to get the doctor and they always let me know the outcome."

The service had employed its own physiotherapist but they had recently left their position. In the interim the community physiotherapist had been supporting people. A new physiotherapist was to start in the near future and would be available 12 hours a week to support people.

Is the service caring?

Our findings

During the inspection we spoke with people who used the service and their relatives about privacy and dignity and we received mixed comments in relation to this. One person said, "I get all the help I need and when I need it." Another person said, "They [staff] always respect your privacy. They knock on my door and preserve my dignity when they wash me." However, one person told us they often had to wait sometime for staff to support them and this had compromised their dignity as they had been incontinent. They told us this had happened on more than one occasion.

A relative we spoke with also told us staff were not proactive at taking the person who used the service to the toilet they told us staff were more reactive when they had been incontinent. We pointed this out to the registered manager at the time of the visit who told us they were in the process of reviewing staffing levels and that they would discuss our concerns with staff immediately to make a positive difference.

This meant that people's dignity had been compromised. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they were happy and that staff were caring. One person said, "Very caring and respectful. I have nothing to complain about. It is a very good care home and I have been coming here for thirteen years." Another person said, "They certainly are. They are very nice people and are very good." A relative we spoke with said, "The care staff are really great and always have a laugh with him."

We found that staff at the service were very welcoming. The atmosphere was relaxed and friendly. Staff demonstrated a kind and caring approach with people they supported. We saw staff actively listened to what people had to say and took time to help people feel valued and important. We saw that staff were able to understand the needs of those people who had limited communication.

During the inspection we spent time observing staff and people who used the service in the lounge and dining area. Throughout the day we saw staff interacting with people in a caring and friendly way. When speaking with people we saw that staff got down to the level of people so they did not appear intimidating and to enable eye contact with the person. We saw that staff provided reassuring touch to people when they needed reassurance.

People were able to come and go as they pleased. One person said, "My friend comes all the time and we go out. I'm going out for my lunch and tea today." Visitors to the service were made welcome and we saw staff updating one relative and having a chat.

Staff used friendly facial expressions and smiled at people who used the service. Staff interacted well with people and provided them with encouragement.

The registered manager and staff showed concern for people's wellbeing. It was evident from discussion that all staff knew people well, including their personal history, preferences, likes and dislikes. Staff told us

they enjoyed supporting people.

We saw that people had free movement around the service and could choose where to sit and spend their recreational time. We saw that people were able to go to their rooms at any time during the day to spend time on their own. This helped to ensure that people received care and support in the way that they wanted to.

We looked at the arrangements in place to ensure equality and diversity and how the service supported people in maintaining relationships. People who used the service told us they had been supported to maintain relationships that were important to them. Relatives told us they were made to feel welcome and encouraged to visit at any time.

At the time of the inspection people who used the service did not require an advocate. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. The registered manager was aware of the process to follow should an advocate be needed.

Is the service responsive?

Our findings

During our visit we reviewed the care records of four people. Care records contained some information about the person's likes, dislikes and personal choices. This helped to ensure that the care and treatment needs of people who used the service were delivered in the way they wanted them to be. Some care plans were better than others. For example the hygiene and dressing care plan for one person informed staff not to use soap on their face and to ensure cream was applied if their skin was dry. Another care plan informed that the person liked their hair to be washed, conditioned and then styled. However, some care plans were quite task orientated and did not contain sufficient detail to be person centred. For example the communication care plan for a person stated that staff should 'observe body language for signs of distress' but the care plan did not give further information about what body language this person would display if they were distressed. One person was identified as being at risk of pressure ulcers. There was a skin care and pressure ulcer prevention plan on file that listed applying cream, putting a bandage on and checking and documenting as ways to mitigate risk. However, there was insufficient detail and nothing about position change or nutritional screening. Another care plan informed that the person liked to wear nice clothes but did not state what these were.

Records were not always reviewed and updated on a regular basis. For one person there was information stating that hand exercises were to be done daily and photographs had been included to show staff exactly how to do this but there was no record to show that this was taking place and it was not mentioned in daily notes. The document was dated 3 December 2014 and stated it was to be reviewed on 9 February 2015. There was no review recorded. There was also a sheet to record when this person had their hand splints put on or taken off. This had been completed by staff but not on a regular basis and if hand exercises were to be done daily then the hand splints should also be removed daily as the exercises were done without the splints in place.

We noted other gaps in recording. One person had a position record in place but the most recent documents had not been correctly completed. For example how often the person was supported to change position, settings for their mattress and how often the mattress was to be checked were all left blank. A skin integrity assessment on 30 September 2016 identified an area of redness on the person's body but there was no record of this being reported to the nurse and no follow up documented.

This meant care records were not detailed to ensure that care was delivered in a person centred way. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service employed an activity co-ordinator and a volunteer co-ordinator who worked closely together to provide people with a range of activities. A number of volunteers also worked at the service. At the time of our visit volunteers came into the service four days out of seven, they helped with activities, for example holding a coffee morning every Tuesday and supported staff when people went out.

We spoke with the activity co-ordinator who told us about a varied activity programme which included arts

and crafts, quizzes, regular trips out and other in house entertainment. We were told how one person had been supported to travel to a family wedding in another part of the country. The service had made two drivers and a care worker available to facilitate this. This person also attended a local church regularly and was supported to do this independently.

The service had a room dedicated for activities. This was a large bright room that contained materials and equipment for use during activity sessions. Photographs on the wall showed people engaged in a number of activities inside and outside of the service such as pub visits and cycling. A relative confirmed to us that the photographs were recent and were changed regularly. We were told that those people who did not wish to engage in group activities were engaged in other ways for example by volunteers reading to them. One person we spoke with had been shortlisted in the registered provider's Christmas card competition and we saw examples of artwork undertaken by other people who used the service. We also observed an arts session going on during our visit. This was supported by the activity coordinator and a relative sat with their family member during this activity which was positively engaged in by those present in a relaxed atmosphere with some jovial banter. Church services were held in the building on a monthly basis.

People told us that staff at the service provided a range of activities and stimulation. One person said, "I like drawing, art, quizzes, karaoke and going out to ten pin bowling, to the cinema and shopping." Another person said, "There is plenty to do. I like to do cooking which they help me with." A relative told us how the person who used the service had a talent for drawing and how they had continued to do this when they moved into the service.

A staff member we spoke with said, "From my experience at other homes I think the care here is good. The food they get and the range of activities are all good. We try to offer them different things to do. They have done table tennis and we even got a full curling set after the last Olympics, they were really into that for a while.

The registered manager and staff were able to explain what to do if they received a complaint. We were shown a copy of the complaints procedure, which gave people timescales for action and who to contact. There had been no recent complaints received. Minor issues were logged by the registered manager and we were shown the register of these. One person had complained about the type of peas that were served and it was logged that they would be purchased 'off contract' in order to meet with the persons preference. Another comment had been made about the lack of a physiotherapist based at the service and we were told that one has now been recruited to work 12 hours a week. We were also told that a member of staff was also going to be trained to provide physio support.

Is the service well-led?

Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We were told that a service audit was done by the registered provider on an annual basis and this had been scheduled to take place this year but was put on hold as the service was due a CQC inspection. The registered manager told us nurses completed weekly and monthly audits on medicines. We saw evidence to confirm medicines audits had been completed on a monthly basis until June 2016 but not after this date. We could see that errors were picked up by the audits for example some missing signatures on medicine records but there was no clear record of what actions were taken after they were identified.

A two yearly Health and Safety audit was carried out by the registered provider and monthly health and safety audits were also carried out internally by a senior member of staff who was the service's designated health and safety link. However these had failed to pick up that the water temperatures had not been checked consistently. We were told that a monthly audit of care plans was carried out but these audits had failed to pick up on the errors and omissions within the care plans that we found. No infection control audit was done but we were told that rooms were checked by staff daily.

The registered manager told us that general staff meetings were held three times a year but meeting notes we looked at during the inspection confirmed that staff meetings were not happening as often as this. We saw minutes from a meeting held on 12 April 2016. Prior to this the most recent meeting was August 2015. The registered manager told us they were looking at, "Finding another way of communicating to staff." There was a nurses meeting scheduled for the day after our inspection. The last nurses meeting minutes were dated January 2015.

This meant systems of good governance were not operated effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager who was registered with the Care Quality Commission in January 2014. We received comments from people who used the service and relatives about the registered manager. One person said, "[The registered manager] is a really nice person and it is very well managed." Another person said, "The manager is approachable and does listen, but takes no action." One relative said, "I would rate it [the care home] very highly. They [the registered manager and staff] are very approachable and deal with any issues. I wouldn't want [person who used the service] anywhere else – put it that way." Another relative said, "[Name of registered manager is very approachable. I can email her or talk to her whenever I need to." Another relative said, "You can talk to [name of registered manager] but nothing ever gets done."

When we asked staff about the registered manager they gave us a mixed response. One staff member said, "If I have any problems I can approach the manager. I get on well with [name of registered manager]." Another person said, "I have a very supportive manager. I am very happy with the support I receive and I know that I can contact [registered manager] at any time. I can call them if they aren't in the office and know

they will respond." We asked another staff member if the registered manager was approachable, they said, "Yes and no it depends on the day and how they are feeling." Another staff comment included, "Yes and no, it depends what it is. I feel like sometimes I have to dig to get an answer as you don't always get feedback."

Staff surveys were undertaken by an independent organisation but the response rate was too low to generate any results. This had been the same in previous years. The format of the survey had been changed to try to increase responses but this had not been successful.

The registered manager told us about their values, which were communicated to staff. The registered manager told us of the importance of honesty, being open and transparent and treating people who used the service and staff as individuals. They told us that they had an open door policy in which people who used the service and staff could approach them at any time.

The registered manager told us meetings took place with people who used the service and relatives to keep them informed and to encourage people to share their views and ideas. We looked at the last meeting notes of May 2016. Topics discussed included menus and a food questionnaire. People had also voted on a selection of pictures to put up in the hallway. We were told about another meeting called 'Future Choices' that was organised by the registered provider and took place over two days. People who used the service and relatives told us there was another meeting planned for 14 October 2016.

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 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	People's dignity was compromised on occasions with staff arriving too late to provide their personal care.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Systems were not in place to make sure people received their medicines as prescribed. Guidance on 'as required' medicines was not available. There were gaps in the recording of fridge and room temperatures. Records of medicine error investigations were not available for inspection.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Mental capacity assessments were not decision specific. Best interest decisions were not recorded in care plans.
Treatment of disease, disorder or injury	
	Care records were insufficiently detailed to enable staff to provide safe care and treatment. Care records had not been reviewed and updated on a regular basis.
	Quality monitoring was ineffective and did not pick up on the issues we found at the inspection of the service. Staff meetings were infrequent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not consistently received supervision. Staff appraisals were out of date.
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	