Oakridge Care Homes Limited

Melbourne House

Inspection report

23-35 Earlsdon Avenue South
Earlsdon
Coventry
West Midlands
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Tel: 02476672732

Date of inspection visit:
14 March 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

We carried out this inspection on 14 March 2017 and it was unannounced.

Melbourne House provides care for up to 33 older people in Coventry. At the time of our inspection there were 29 people living at the home. The building was divided over three floors. Some people stayed at the home for short term 'respite' care.

A registered manager was in post and had been for five years. 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.

At our previous inspection in October 2014 we rated the service as requires improvement in the areas of 'safe' and 'effective'. We found risk assessments and care plans were not always up to date. Staff did not have an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Social stimulation for people could be improved. At this visit we found staff knowledge around MCA and DoLS was improved, however care records and risk assessments continued to require further improvement. There remained little social stimulation for people.

We could not be sure people who used the service were safe. Risks to people's safety were identified by staff, however ways to manage and reduce these risks were not always documented correctly to ensure a consistent and effective approach was taken.

Care records contained information for staff to help them provide personalised care, however some information was missing about people and how they should receive their care. Staff knew the people they cared for well.

There were enough staff to care for the people they supported. Checks were carried out prior to staff starting work to ensure their suitability to work with people who used the service. Staff received an induction into the organisation, and they completed training to support them in meeting people's needs effectively.

Staff had a good understanding of what constituted abuse and knew what actions to take if they had any concerns.

People and relatives told us staff were caring and had the right skills and experience to provide the care required. People were supported with dignity and respect and people were given a choice in relation to how they spent their time. Staff encouraged people to be independent.

People received medicines from staff who were trained and competent to do this. Medicines were administered correctly. For medicine taken 'as required' (PRN), guidelines were not always recorded to tell

staff when people needed this.

Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making, which included arranging further support when this was required.

People had enough to eat and drink during the day, were offered choices, and enjoyed the meals provided. Special dietary needs were catered for.

People were assisted to manage their health needs, with referrals to other health professionals where this was required.

There were some social activities to keep people occupied and plans were in place to improve these further.

People were given the opportunity to feedback about the service they received through surveys. Meetings for people and relatives were held.

People knew how to complain and these were recorded and responded to, to people's satisfaction.

Staff had positive views about the management of the home. Staff told us they could raise concerns or that these would be listened to. There were some formal opportunities for staff to feedback any issues or concerns at team meetings.

There were some processes to monitor the quality and safety of service provided to ensure staff were following policies and procedures.

Checks of the environment were undertaken and staff knew the correct procedures to take in an emergency.

We had received the required notifications to enable us to monitor the service. The provider displayed the ratings from our previous inspection.

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 received support from staff who understood the risks related to their care, however these were not always documented correctly so staff consistently knew how to reduce the risks. People received their medicines from staff who were trained and medicines were administered correctly. However, protocols were not in place for people who needed PRN medicine to ensure these were given consistently. Staff had a good understanding of what constituted abuse and knew what to do if they had any concerns. There was a thorough staff recruitment process and enough experienced staff to provide the support people required.

Is the service effective?

Good

The service was effective.

Staff were trained to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making. People were supported with their nutritional needs and enjoyed the meals. Managers referred people to other professionals if additional support was required to meet their health or social care needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate. Relatives told us staff were caring and respected people's dignity and privacy. People were encouraged by staff to be as independent as possible and were given choices about how they spent their time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received a service that was based on their personal

preferences. Care records contained information about people's likes, dislikes and routines, however other information about people's care needs was missing or required updating. People enjoyed some activities; however there were limited activities currently available. Complaints were recorded and responded to by the management team.

Is the service well-led?

Good

The service was well-led.

Staff felt able to raise concerns with the management team. Some quality assurance systems were in place to identify any issues and drive improvement at the service. People and their relatives told us managers were approachable. There were opportunities for staff to discuss any issues or concerns at meetings. People living at the home had opportunities to feedback any issues by completing surveys and attending planned meetings.

Melbourne House

Detailed findings

Background to this inspection

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At our previous inspection in October 2014 we rated the service as requires improvement in the areas of 'safe' and 'effective'. We found risk assessments and care plans were not always up to date. Staff did not have an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Social stimulation for people could be improved. At this visit we found staff knowledge around MCA and DoLS was improved, however care records and risk assessments continued to require further improvement. There remained little social stimulation for people.

Risks to people's safety were identified by staff, however ways to manage and reduce these risks were not always documented correctly to ensure a consistent and effective approach was taken.

Care records contained information for staff to help them provide personalised care, however some information was missing about people and how they should receive their care. Staff knew the people they cared for well.

There were enough staff to care for the people they supported. Checks were carried out prior to staff starting work to ensure their suitability to work with people who used the service. Staff received an induction into the organisation, and they completed training to support them in meeting people's needs effectively.

Staff had a good understanding of what constituted abuse and knew what actions to take if they had any

concerns.

People and relatives told us staff were caring and had the right skills and experience to provide the care required. People were supported with dignity and respect and people were given a choice in relation to how they spent their time. Staff encouraged people to be independent.

People received medicines from staff who were trained and competent to do this. Medicines were administered correctly. For medicine taken 'as required' (PRN), guidelines were not always recorded to tell staff when people needed this.

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Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed and found they were administered correctly. One relative told us, "They have the medication sorted, one of the staff, a senior, looks after it. A doctor calls here every Tuesday, there are no concerns." We observed medicines being administered to six people. People were offered water to take their medicines and were asked discreetly if they needed pain relief. One person was prescribed pain relieving gel and they were asked if they needed any help to apply this, however they declined, as they were able to this for themselves. People had individual boxes which had their photographs on to reduce the risk of error when administering medicine. Medicines administration records were completed correctly.

Some people required medicine 'as required' known as 'PRN'. Protocols were not in place to instruct staff when people required this, if people could not tell staff themselves. However, staff could tell us the signs that people required these medicines as they knew people well. For example, staff told us one person screamed out if they were in pain and required pain relief. One senior staff member told us, "We know people and if they need any pain relief. We always ask and check the last time people had them." This was to ensure people did not take more than the required amount in a 24 hour period. This was administered, but there was no written guidance in place for staff. The registered manager told us they would put in place the PRN protocols 'straight away'.

Medicine was not always being stored at the correct temperature to ensure it remained safe and effective to use. On the day of our visit we saw the fridge temperature was higher than is recommended. We asked the registered manager about this and they told us this would be addressed immediately. Although checks were completed around medicines this had not been identified.

Senior staff had completed training in medicines administration and competency checks took place to ensure they remained safe to do this. One staff member told us, "The manager observes me once or twice a year, we have training to make sure we are able to handle medicines safely." We saw their most recent training certificate dated January 2017 and a competency check took place in November 2016 where no issues were identified. The manager told us if there were any concerns raised or they noticed staff were not administering medicine correctly, 'refresher' training would be arranged.

Staff understood the potential risks when providing people's care and how to support people safely. However, we found some risks had not been reviewed monthly in line with the provider's policy. We could not be sure risk assessments were always followed and action was always taken to manage identified risks.

Senior staff updated risk assessments when people's needs changed. Some risk assessments had been updated and were correct. For example, one person was at risk around their skin and this was documented. We saw that checks had been made by visiting nursing staff, these were recorded by staff and up to date, equipment had been provided to prevent the skin deteriorating and their skin remained 'intact'.

Another person was at risk of falls. This had been reviewed in March 2017. Risks had been identified such as

unsteady gait (the way they walked), slips or trips when walking around, hazards in communal areas and bedroom. Action to reduce this included reminding the person to wear certain footwear and to keep their bedroom free from hazards.

However, one person was at risk of weight loss and had lost 5.7kg between January and March 2017. In January 2017, the GP had visited this person and prescribed special drinks to increase their weight. The deputy manager told us the person had never had these drinks as there had been a mix up with the pharmacy and they had not been dispensed. This had not been identified by staff or action taken to address this. On their risk assessment staff were instructed to refer them to a dietician if they lost weight, however this had not happened, although the person's risk assessment had been reviewed in March 2017.

We found another person was at risk of losing weight. Staff had been weighing them monthly and recording this, however we could not see that consideration had been given to whether they were losing or gaining weight. In February 2017, they weighed 42.5kg, however in March 2017 their weight was recorded as 33.8kg. The registered manager told us this was incorrect, and the person's weight had remained stable. However staff had not noticed the significant difference in the person's recorded weight or raised this as a potential concern.

Some other risk assessments were completed for areas such as use of hospital beds, however these had not been reviewed since August 2016. We discussed this with team leader who told us they were aware that some information was out of date and they were in the process of reviewing the risks assessments.

People told us they felt safe at Melbourne House. Comments from people included, "I do feel safe here and well cared for." Relatives told us, "I have a relative here and I feel that they are safe."

The provider's recruitment procedures minimised the risk to people's safety. Prior to staff starting work at the home, the provider checked their suitability to work with people who lived there. Background checks were obtained and references were sought. We checked two staff files and saw these had been completed. Comments from staff included, "Recruitment was thorough, I had an interview with the manager and then had to wait for reference checks before I could start," and "I got DBS clearance before I could work with people." The DBS (disclosure barring service) completes background checks to ensure as far as possible that staff are of suitable character to work with vulnerable people. The registered manager told us they were planning to 're - do' DBS checks for staff who had been there for a period of time, in line with the provider's policy.

Most people told us there were enough staff to support them at the times they preferred, comments included, "I don't have to wait long for a carer to come and help me." Relatives told us, "Yes, I think there is, (enough staff)." However, some other people told us, "There is not always enough staff on at weekends, but there is usually in the week" and "Staff are not always available to take me to the toilet, but they do tell me how long they will be".

Staff confirmed there were enough of them to meet people's needs. One staff member said, "We have four staff on nights, it's more than enough to check people through the night to make sure they are comfortable." Another staff member told us, "Yes, there is enough staff and they can always find staff to cover if necessary." There were no staff vacancies currently and agency staff were used occasionally at night so that staffing levels were maintained. Observations showed staff were available when people needed them.

Staff understood the importance of keeping people safe and their responsibilities to report any concerns. Comments included, "We have done the safeguarding course. If we notice anything we have to report it. It

could be people neglecting themselves, bruises for no reason. We would report to the senior or team leader and it would be taken to the manager. Abuse is very serious."

Staff were able to give examples of what might be cause for concern, what signs they would look out for and what action they would take. One staff member commented, "You might see bruises, things like that. People might also tell you something is wrong. If I was concerned, I would let the manager know straight away."

Staff were confident the manager would take action if they reported concerns. A staff member said, "[Manager] is on the ball, straight on the phone to social services if there is cause for concern." Staff told us if no action was taken they would speak with the deputy, team leader or phone CQC.

Staff knew of their responsibility to whistle blow (raise concerns about other staff). The policy was included in the staff handbook and also displayed in the staff room. Staff told us, "There is a whistle blowing policy and there is an 'open door' policy here, I would speak up if I needed to" and "The manager's door is always open, I know I have a duty to speak up if I witnessed any poor practice." We found for some staff their training around safeguarding people had lapsed. We raised this with the registered manager who told us this had now been arranged for April 2017.

Staff were aware of the procedures to take in an emergency and if the home required evacuation. One staff member told us, "We are all given fire training and know how to evacuate." Another staff member told us, "There are no issues around safety of residents. We have fire drills, any equipment not working is fixed." Personal emergency evacuations plans were in place and told staff about people's care and support needs in the event of an emergency. We discussed this with the registered manager who told us that some newer people did not have a plan in place, however they were addressing this. Fire safety checks had been completed and also fire drills.

Accidents and incidents were documented for each person. We saw two had been recorded for February 2017; there was no pattern or trend identified to these which may have been used to prevent these further.

A maintenance person was employed at the service, they told us, "We have processes for checking equipment, everything is serviced as it should be to make sure it's safe to use." Safety checks of the environment were completed such as gas safety, electrical and call bell checks. Most equipment had been serviced to ensure it remained safe to use. Given the issue of possible inaccurate weight recordings, we were unable to see when some weighing scales had been checked and the registered manager was unable to provide us with this information. However they told us they would be checked now and servicing completed if this was required.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received and staff had the skills and knowledge to meet people's needs. One person told us, "I chose to come to this home on respite. Staff work very hard and do a good job." One staff member told us, "We all talk to each other and decide who will do what. We have good team work which means people are cared for well." One visiting professional told us they had no concerns about the care people received.

Staff received an induction when they first started working at the home. An induction programme covered roles, policies and procedures. A staff member told us, "I had a buddy and shadowed about three shifts, it was enough for me." Shadowing is working alongside another staff member. The registered manager told us they also provided training as part of the induction and this was through the local authority.

Staff received training suitable to support people with their health and social care needs. The registered manager told us, "I have tried to put all staff on the health and social care NVQ level two course." All staff had completed, or were in the process of completing, this qualification. The deputy manager had almost completed a level 5 qualification in care, and told us they were really encouraged to develop their knowledge. All new staff completed the Care Certificate. The Care Certificate sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment.

Staff told us, "We have good training here, we have dementia, mental capacity, diabetes" and "We are asked to reflect on training and share with other staff at meetings." Staff told us about training in relation to dementia care, "I had dementia training, I learnt about the condition. It made everything make sense to me so I understand how to care for people." Another staff member told us, "I had person centred care training. I learnt how everyone likes things to be cared for differently, it opened my eyes." They gave us an example of this such as how they greeted people by their preferred names. They told us one person liked to be called 'Mrs….', rather than staff using their first name.

A 'handover' meeting was held each day as the shift changed, where information was shared by staff about people's health or well-being. Staff told us they found the handover useful, they said, "We always get handover. It's informative and we find out what has been happening," and "It's a good way of finding out information so we know what care people need."

We observed the handover meeting, however this was in a communal area and confidential information was being discussed with people living at the home seated nearby. We raised this with the registered manager who told us staff were aware of this, and the handover was done discreetly. However, they told us they would consider if there was a better place for staff to meet where they could still be available to monitor the people living in the home.

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. 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 (DoLS) were being met. We found two of the people living at the home were having their liberty restricted. Decisions had been correctly taken to submit applications to a 'Supervisory Body'. At the time of our visit the applications had been submitted or authorised.

The registered manager told us, "DoLS is when you are stopping the client do what they want to do but you are protecting them. Mental capacity is about decision making. Someone might be able to choose what clothes to wear, but not all things. If a person lacks capacity you need to consider the power of attorney and who makes the decisions. I have forms I complete which look at which areas people can decide. I would liaise with social services or Age Concern if there were any areas I was not sure about with capacity."

Staff told us one person was at risk of getting lost if they went out alone, therefore a DoLS was in place for their own safety. We observed the person try to leave on several occasions and staff supervised them from a distance whilst they walked freely around the home and garden. Staff told us, "[Person] goes out for a walk most days with a member of staff. We take them to keep them safe and it helps them to stay calm." We saw this happened during our visit.

Most people at the home could make some day to day decisions. Staff told us they had received training in MCA, they said, "People have the right to refuse and make their own decisions," and "People make decisions for themselves here." For example, one person was overweight and receiving support from their GP and a dietician to manage this. Staff said," We encourage them to eat healthily and we explain the benefits of a healthy diet, but it is up to them what they eat and they have the capacity to decide."

Another person had their medicine given 'covertly'. This is medicine that is hidden, usually in food. We identified that if this was not taken, it could have a negative effect on their health. The person did not have capacity to make this decision and did not always want to take this, so the medicine was dissolved in water. We saw the correct steps had been taken and a best interest meeting had been held with their family, the GP and pharmacy around this.

Staff sought consent from people before supporting them with care. The service supported some people who did not always want to accept support with their personal care. Staff told us how they approached one person, "You can use humour and try to be light hearted about it. But, if they really don't want to, we encourage, but if they are adamant we'll pass the information on to the next shift and perhaps try again later." We observed people being supported by staff for example with their medicine, and consent was obtained.

People's nutritional needs were met with support from staff. Comments included, "The staff know that I am a fussy eater and they know what I want to eat or drink. I have fruit most days especially bananas. I just need to ask if I want a drink" and "The food is good, it varies and can be sandwiches, soup or sausage rolls. There is a trolley for drinks mornings and afternoon. If I needed anything more I just have to ask." Relatives told us, "I have no worries about my relative, they have put on weight since they have been here," and, "The food is very good, [Person] has to be fed, the staff are better at it than me."

We observed people over the lunchtime period, enjoying their meal and being supported and encouraged

by staff at their own pace. We observed one person who did not wish to eat their meal. The chef offered them an alternative and they had this instead. People were offered two lunchtime hot meal choices and staff showed people the plated choices on request as some people were unsure what the meals were.

The chef told us if a person wanted something specific to eat, they would buy this. For example, one person had asked for a certain soup and so this was purchased. The menu changed four weekly and was seasonal. Snacks and drinks were available for people during the day and we saw these offered.

People who had special dietary needs were supported. Nutritional profiles were held by the chef who had a good understanding of people's needs. One person had dietary preferences in relation to their culture, this was respected. One person had been on a special diet where their food was being mashed, however staff told us this was no longer required. Staff were aware of this, however it had not been updated on their care record. Some people were diabetic and the chef made suitable alternatives for these people.

People were supported to manage their health conditions and had access to health professionals when required. One person told us, "If I feel ill, I tell a member of staff or nurse and they'll get the doctor if I need them, but that hasn't happened very often." Another person told us, "If I have any aches and pains I tell the carers straight away."

One family member told us, "My relative has not been well since Christmas and the staff have worked hard to keep them here as they didn't want to go to hospital. My relative has said that they could not have got better care anywhere else." Another relative told us, "As soon as it was obvious that [Person] had to go to hospital, they contacted me straight away. This was very reassuring. The staff here were monitoring my relative and kept mentioning it to the doctor."

The registered manager told us they had a good relationship with the local GP surgery and felt well supported by them. Staff told us, "We get very quick support from health staff, if we had to wait we would report it." The district nurses came into the service and people had been visited by other professionals including social workers, the optician and speech and language therapy. Dentists and the Podiatry Services also visited to support people.

Good

Is the service caring?

Our findings

People told us staff were kind to them and caring in their approach. Comments included, "It feels like home from home for me," "I get good care here, I can't complain," and "I do like it here, it is like home."

One family member told us, "Yes, staff are very caring, I think people receive the best care possible." Another relative told us, "My relative came in as they could not cope living at home. I looked at quite a few homes and this seemed the best." One relative told us their family member was 'always smiling and cheerful,' and another relative described the staff as 'astonishingly caring'.

Throughout the day we observed positive interactions between people and staff. People appeared comfortable with staff, and we saw staff speaking with people with kindness and respect. We heard some laughter and banter, which people responded to well.

Staff told us what 'caring' meant for them, a staff member said, "The atmosphere here is good. People get a lot of choice. Staff are respectful. We think about each person and how they like to do things. Everyone is different." Staff told us the home had a 'mix of cultures' and respecting people's cultural and religious needs was really important to them.

Staff told us they were encouraged to sit and talk with people when they wanted to. One staff member commented, "We like to chat. You can tell sometimes if people don't feel themselves. I sat and chatted with someone for ages the other day. You have to make time for people. It's how you would want your own relatives to be treated." Some staff told us how they looked at people's photographs to start conversations. They explained a couple lived in the home and they sometimes proudly showed off their wedding photos and shared their memories with staff. One said, "It's so lovely to sit and listen to their stories of when they were young and so in love."

One person told us how much they enjoyed the birds coming to feed at their bedroom window and showed us where staff had put up a bird feeder for them, to encourage this.

Staff told us they enjoyed working at the home, they said, "We are a happy staff team which means we are committed to meeting people's needs," and "It's a lovely homely environment, we all really care about each other." We observed staff supporting people with kindness during our visit, being respectful and encouraging to people. On occasions staff knowledge of the person and their preferences were clearly displayed. For example, one person had been in the army and stationed in a certain area. Staff knew this and talked with the person, who responded well to conversations about this.

People were given choices around their care. One person preferred to spend their time in their room. Staff told us about this person who liked their own company, and a quiet environment. Another person's preference was to sleep in an armchair and this is what they did. One person enjoyed a whisky each night and staff ensured they could have this. We observed staff asking a person which equipment they would prefer to use so they could help them move between chairs, as this depended on how the person was feeling

that day.

People were encouraged to be independent. Staff explained how some people washed their own hands and face and they always gave people time to complete what they could for themselves. One person had some medical equipment they had to wear. The person told us they chose when they wore this or not, independently of the staff.

One person went out independently to the local shops. Staff told us, "[Person] nips out sometimes, they have a mobile phone so can call us if they need any help." They explained that if the person was away over a certain amount of time they would phone them to check they were okay. Another person liked to clean their own bedroom as this was something important to them, so staff had provided them with the equipment to do this.

People's rooms were individualised, contained their own personal items and people were encouraged to make these comfortable to suit their needs and preferences. One person told us, "My son came and looked at the home and we chose this room. The owners did alterations for me, so I like my room. The only heating is on in here at night time, which suits me."

Some people told us they found the home too warm. Comments included, "It is very hot in this room. The window kept shutting so I have to keep it open and I leave my door open. I also have a fan it is so hot" and "The house is kept too hot, it is set at about 26." We asked the registered manager about this and they told us the heating engineers were visiting that day and they would adjust this.

People were encouraged to keep in touch with their families and there were no restrictions on visiting times. Visitors told us they felt welcomed at the home. Some people used a computer system to talk with relatives who lived a distance away.

People were supported with privacy and dignity. One person told us, " I came to this house through choice, I feel that I get good care and I am treated with dignity and respect, I go down to the pub in my mobility scooter every week as it is just down the road. I take my mobile phone with me in case I have any problems. I can see everyone as they come and go from the house which keeps me mentally active." Another person told us, "I am treated with respect and my care could not be better."

Staff gave an example of how they would approach someone who needed support with their personal care, they said, "I would speak quietly and discreetly and ask the person if they wanted to go to the bathroom. It is about their privacy and dignity. You don't want things shouted across the room." Other staff told us they always knocked doors and we saw them do this.

Due to the small size of one person's room they were unable to close their en-suite bathroom door as their armchair blocked this. The person was unhappy about their level of privacy whilst in their bathroom. We raised this with the registered manager who told us that unfortunately this had been the only room available when the person came and they were aware that this remained a problem currently. However, the person was due to leave the home shortly as they had been staying for a short time only.

Some people shared a room and a curtain separated the room for privacy. The registered manager told us they liked this. We were not able to confirm this with the people, as they were unable to tell us about their preferences.

Requires Improvement

Is the service responsive?

Our findings

People had mixed views about whether the care they received met their preferences. One person told us, "I like to have a full body wash each day as I don't care much for showers," and they told us they were happy with their care. However, another person told us, "Whenever I want a shower I can have one, it can be a bit rushed. They get me up too early, it is supposed to be 7am, but most mornings it is 6am."

People were assessed before coming to the home to ensure that their care and support needs could be met there. Information was obtained about people's family histories, likes and dislikes from people and their families. Care records contained information about routines, preferences and what was important to people.

Staff knew the people they supported well. Staff could explain to us in detail about the people at the home. One staff member told us, "We rarely use agency staff, which means people are cared for by staff that they know." 'Keyworkers' were allocated to people and these staff ensured people were supported with their more individual needs such as clothes, toiletries and to liaise with families. One person's last keyworker review had taken place in October 2016. Staff told us these should happen each month to ensure people were involved in the review of their care.

Although care records were 'person centred' and contained information which enabled staff to know people better, some care records we reviewed had not been updated, did not detail the level of support people required or how staff were to provide this support. Staff told us care records were updated as people's needs changed, they said, "If we think there's a change, we mention it to the team leader and they arrange for it to be reviewed."

Care records were in the process of being updated by a team leader. The registered manager told us, "This is my main concern, it is why I asked the provider to get a team leader and I am training the team leader to do this (review care plans)." They told us they had been completing this since December 2016 and this was currently a priority for them.

We found some care records had been reviewed monthly in-line with the provider's procedures. One care worker told us, "We fill in skin charts, it gives us an overview of skin health. If we notice changes we call the district nurse to come and check skin." They explained they looked for any red or sore skin or moisture lesions. This was to address any possible developing pressure areas.

However, one person had 'chronic' constipation and was on a daily chart to monitor this. The chart was last completed over one week in January 2017 and for a one week period in March 2017. We asked the registered manager about this, and they confirmed staff had not completed these records correctly and this would be followed up and addressed immediately.

Some care plans lacked the detailed information about people which staff knew. For example, staff told us that if one person was hungry or thirsty they would stick their tongue out. If they had had enough to eat they

would spit their food out. Another person was prone to chest infections, the GP had advised they go back to bed if they appeared 'chesty' to relieve symptoms. Staff knew this information, however it was not recorded in care records so we could not be sure staff would care for people consistently.

One person chose to get up early in the morning and staff knew this. Staff told us the person was unable to use a call bell and so was observed hourly by night staff and a movement sensor and a crash mat were in place. However, this information was not recorded in their care plan.

Review meetings were held annually or before, if required. We were aware a meeting was being held on the day of our visit with one person, their family and other professionals. Relatives told us they were involved in the care decisions with their family members. Comments included, "I am always involved in their care plans," and "We sorted out our relative's care plan initially, and there have not been any changes over the years. If there are any health issues the home contacts us straight away which is reassuring.".

Some people told us there was enough to do to keep them occupied. Events were organised such as a summer barbecue and Christmas celebrations. One person enjoyed going to the pub and a hairdresser visited the home. Some people went out shopping or on trips. Raised flower beds were in place in the garden if people wished to do be involved in gardening.

We observed one member of staff trying to get a person to catch a soft ball and another person was doing a jigsaw with a staff member. Staff were sitting chatting with people. One person preferred to stay in their room and they liked their nails painted, to read a book or be visited by their family. Another person said they preferred listening to the radio and watching TV, over other activities.

Some people told us activities could be better. Comments included, "We don't have any activities. They showed us a film last week, but I am happy just reading." A relative told us, " There used to be a really good activities co-ordinator but she left, then the next one left and now there is no-one doing activities. Any activities that are done are not very varied, but I know that people like my relatives are getting older and sleeping more, so probably don't always want to take part in anything." Another family member told us, "We would like to see more activities, but we are not sure if our relative says 'no' to things and that is why nothing happens."

A full time activity person was employed, however this person was currently on maternity leave. The registered manager told us they had advertised the role and were intending to employ someone, however wanted this to be a person with the right experience and skills. They told us they were aware this would improve the current activities further.

We looked at how complaints were managed by the provider. People told us they did not have any complaints, but they could complain if they needed to, and would go to the manager or senior staff. One person told us, "I am happy to mention any concerns to staff." One relative told us, "If I had any concerns I would talk them through with [Manager]. Another relative told us, "If I had any issues I would raise them." One relative told us one of their family members had complained about one area of the home being untidy before, and this had now been addressed.

Complaint forms were available to people and visitors in the foyer of the home. A system to manage complaints was in place. The last recorded complaint was in 2015. A person had complained the TV was broken and a new one was ordered the following day. Comment cards were available for people and visitors to complete, and compliments had been recorded.

Good

Is the service well-led?

Our findings

We received positive views about the management of the home from visitors. One relative told us, "The staff are good, [Registered manager] won't tolerate problems. They run a tight ship." Another relative told us, "It's run very well with a lot of care and consideration." A visiting professional told us, "The management have been very good." The management team consisted of the provider, the registered manager, a deputy manager and a team leader.

Staff were also positive about the management of the home, "[Manager] is lovely, very approachable, like a second mum to me, they really care," and "Managers are really visible, always on the floor, they know what is going on." Staff told us managers were 'hands on' with care and would help care staff if they were busy. One staff member told us that the registered manager was the most efficient manager that the home had had, and the deputy manager was also very good.

The management team was supported by the provider who also held one to one meetings with staff. One staff member told us the provider came in to talk with them and check if they had any problems, they said, "The owner visited yesterday, they are very approachable. They show a real interest in what goes on here."

Communication between the management team was good. The deputy manager told us, "Every Monday morning me and [Registered manager] have a meeting to review how things have been over the weekend and plan for the week ahead." This was beneficial as they could plan for any staff sickness, leave or training. Management meetings were also held every month to discuss the leadership of the service and people living there. They told us, "We are always 'on the floor', observing staff, to make sure they are providing high quality care to people."

Managers were available to support staff during the night and at weekends. Staff confirmed managers took it in turns to be 'on call' and said, "Manager's answer the phone if we need advice, they are always helpful and listen to us."

Staff had formal opportunities to meet at team meetings and in one to one meetings. A staff member said, "We have team meetings a few times a year. They are well attended and we speak up about anything that needs to be improved for people." The deputy manager told us, "We have full team meetings every six months. We give the staff four weeks' notice so they can attend, as it's hard to get everyone together otherwise." The last team meeting was held in January 2017.

Annual appraisal meetings gave staff the opportunity to review their roles, and look at their training needs and goals. The manager explained a scoring system was used to identify if they needed to have a further one to one meeting with that person so that they could further discuss any issues.

People were given the opportunity to raise any issues or concerns they had. Meetings took place for people at the service and their relatives, a couple of times per year. The last meeting was in January 2017. Minute's showed people were happy with how the home was being run and felt involved in this, for example with

refurbishment plans and in relation to food menus.

Questionnaires had been sent out in January 2017 to obtain some feedback about the service. We saw five had been returned with comments including, "We could not wish for a nicer home." People all said they were either 'satisfied' or 'very satisfied' with the service they received.

A manager's 'surgery' was held where people were able to go out with the manager to a place of their choosing and spend time, if they wished to discuss anything with them. A visit has been made with one person to a motor museum. Another person had gone to a Hindu temple at their request.

Some quality assurance systems were in place to ensure staff worked to policies and procedures. For example, the registered manager worked some day and night shifts to observe and feed back to staff. Competency checks were carried out around medicines. The manager had identified that care records were a priority and they were being updated by the team leader. Activities had also been identified as requiring improvement and a co-ordinator was being employed.

Further developments were being planned at the home with new furniture being purchased and a programme of refurbishment. One staff member told us, "We are having a bit of a refurb with new furniture to improve the environment for people." Some furniture was being delivered on the day of our visit. A service improvement plan had identified the new furniture was required. Fire doors were also being replaced and some new equipment had been ordered.

Plans were in place to develop a staff incentive scheme. The manager told us they had devised task sheets for each shift to show what is expected of staff, as there had been some conflict around staff allocation of roles and tasks previously.

The registered manager told us they were proud of the people at the service that left the home after respite and that most people were happy and appreciative, she told us, "It is the clients I stand for." They told us that they felt that since the previous inspection, they had improved the service people received.

The registered manager told us one challenge at the service was around storage space. In order to address this, they had contacted the local authority to arrange for some equipment to be collected and a skip had been ordered to remove other broken items of equipment.

The provider understood their responsibilities and the requirements of their registration. They were able to tell us what notifications they were required to send us, such as changes in management, safeguarding and serious injuries. They told us, "I like to report everything, if there is a complaint. I would speak with the local authority commissioners." We saw the previous inspection ratings were displayed.