Acorn Lodge Limited

Acorn Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Acorn Lodge Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Acorn Lodge Care Centre can accommodate 98 older adults who may have dementia in a purpose built four storey building. At the time of this inspection, 94 people were using the service.

This inspection took place on 16, 17 and 23 July 2018 and was unannounced. At the last inspection in April 2017, the service was rated as Good. During this inspection, we found one breach of the regulations and the service is now Requires Improvement. This is the first time the service has been rated Requires Improvement.

The service did not have 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.

Staff were knowledgeable about safeguarding and whistleblowing procedures. Safe recruitment checks were made before new staff began employment. There were enough staff on duty to meet people's needs. Building checks were carried out in line with building requirements. Risk assessments were carried out to mitigate the risks of harm or abuse people may face. People were protected from the risks associated with the spread of infection. The provider analysed accidents and incidents and used this as a learning tool to improve the service.

People's care needs were assessed before they began to use the service to ensure the provider could meet their needs. People and relatives were confident staff had the skills to work with their family member. Staff were supported with training opportunities, supervisions and appraisals. People were supported to eat a nutritionally balanced diet and to maintain their health. The provider understood their responsibilities under the Mental Capacity Act (2005). Staff understood the need to obtain consent before delivering care.

People and relatives told us staff were caring. Staff described how they developed caring relationships with people. Relatives were kept updated on the wellbeing of their family member. Staff were knowledgeable about equality and diversity. People were supported to maintain their independence and their privacy and dignity was promoted.

Care plans were personalised and contained people's preferences. Staff understood how to deliver a personalised care service. The service was meeting people's accessible communication needs. People were offered a variety of activities in accordance with their preferences. The service had a complaints procedure and kept a record of complaints. People's end of life care preferences were recorded.

Relatives and staff gave positive feedback about the leadership in the service. The provider had a system to obtain feedback about the service in order to make improvements. People had regular meetings so their views about the service could be heard. Staff had regular meetings to keep updated on service development and to contribute their views on the running of the service. The provider had several quality audit systems to identify issues to improve the service. The manager worked in partnership with outside agencies to share examples of good practice.

We have made one recommendation about the continued monitoring of staff suitability.

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. Building and equipment checks were carried out. However, the call bell system was found to be faulty and the systems for checking call bells had not picked this up. Recruitment checks were carried out for new staff before they began employment. However, there was no system in place for monitoring the continued suitability of staff.

Risk assessments were carried out to mitigate the risk of harm people may face. Staff were knowledgeable about safeguarding and whistleblowing procedures. There was enough staff on duty to meet people's needs.

There were systems in place to manage medicines safely. Accidents and incidents were recorded and lessons were learnt from these.

Is the service effective?

Good

The service was effective. People had their care needs assessed before they began to use the service. Staff were supported with regular opportunities of training, supervision meetings and appraisals.

People's nutrition and hydration needs and preferences were met through a varied menu. People had access to healthcare as they needed. The premises was designed to meet people's needs.

The service provided care in line with the requirements of the Mental Capacity Act (2005). Staff understood the need to obtain consent before delivering care.

Is the service caring?

Good

The service was caring. People and relatives told us staff were caring and they were involved in decision making about the care delivered.

Staff explained how they got to know people and developed

caring relationships with them.

The provider had an equality and diversity policy and staff knew how to deliver an equitable service.

People's privacy, dignity and independence was promoted.

Is the service responsive?

Good

The service was responsive. Staff understood how to deliver personalised care. Care records were personalised and included people's preferences. The provider had systems in place to meet people's communication needs.

A wide variety of activities were offered to maintain people's well-being.

The provider had a system to handle complaints and to record compliments in order to improve the service provided. People's end of life care wishes were recorded.

Is the service well-led?

Requires Improvement

The service was not consistently well led. There was not a registered manager at the service.

Relatives and staff spoke positively about the service. The provider had a system to obtain feedback from people and relatives about the quality of service delivered.

People and staff had regular meetings so their views could be heard about the quality of the service.

The provider had several quality audit systems in place to identify areas for improvement. The service worked jointly with other agencies to share examples of good practice.

Acorn Lodge Care Centre

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.

This inspection took place on 16, 17 and 23 July 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority with responsibility for commissioning care from the service to seek their view about the service.

During the inspection we spoke with 11 staff which included the manager, four support workers, four nurses, an activities co-ordinator and the chef. We also spoke with four people who used the service, seven relatives and a visiting healthcare professional. We observed the care and support that was provided in the communal area. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed 10 people's care records including risk assessments and care plans and reviewed nine staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

Relatives told us they felt their family member was safe. One relative said, "I know my relative is safe because there is always someone around." Another relative told us, "The staff walk up and down all the time and they're always looking in the rooms and notice if anything needs seeing to." A third relative said, "I've never seen anything that makes me feel that my relative is unsafe."

The provider had safeguarding and whistleblowing policies which gave staff clear guidance on what to do if they suspected a person using the service was being abused. Staff were knowledgeable about reporting safeguarding concerns and whistleblowing. One staff member told us if they suspected somebody was being abused, "First I will talk to the nurse and then I would go to the manager or the nurse will go to the manager. If you see something you know is not supposed to happen, you blow the whistle for action to be done." A second staff member said, "If something is going wrong and nothing is being done in spite of you raising it, then you can call upon CQC and local authority about it. I have had training in safeguarding."

People had risk assessments carried out so that measures could be put in place to keep them safe. Risk assessments in place included manual handling, mobility and falls, skin integrity, social isolation and malnutrition. One person had an assessment for their risk of dysphagia (swallowing difficulties). The risk management plan stated the person received nutrition through a percutaneous endoscopic gastrostomy (PEG) feeding tube but with supervision was able to eat orally. There was guidance on this person's file about thickening their drinks. Each person had a 'safety needs' risk assessment around their ability to summon assistance when needed. One person's 'safety needs' risk assessment stated, "[Person] is able to use call bell and verbalise for help. Call bell to be within reach. Also to be checked hourly by day and night staff."

The call bell system was checked monthly with the most recent check carried out on 6 July 2018. The maintenance person also carried out a weekly random call bell check. However, we noted there was no system in place to check call bell response times. One person told us, "Sometimes it takes about five minutes for them to come, sometimes twenty. The staff have to divide themselves. The night time staff work differently and won't answer calls for up to two hours."

During the inspection, we noted the call bell system was quiet, so we tested two of the call bells on different floors. It was clear the calls were not registering on the central intercom alert system on each of these floors. This meant people could not be assured that staff would respond to their needs in a timely manner.

We raised this with the manager and the clinical manager who took immediate action. The manager contacted the external maintenance company who advised the system needed to be manually cleared and explained how this was done. A new system was introduced by the end of the inspection where the manager and clinical manager checked the call bell system weekly and cleared the system.

Building safety checks had been carried out in accordance with building safety requirements with no issues identified. These included the servicing of moving and handling equipment on 23 February 2018, gas safety

check on 6 October 2017 and portable appliance testing on 23 May 2018.

Records showed the fire service carried out a fire safety inspection on 31 July 2017 with no concerns and a fire equipment inspection was carried out on 20 April 2018. The fire alarm system and emergency lighting were checked in September 2017. The provider had updated their fire risk assessment on 26 October 2017 and the last fire drill was done on 21 May 2018.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. Staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had provided written references.

The service had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK and ensures nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards.

The provider ensured new staff had undergone criminal record checks to confirm they were suitable to work with people. However, there was no system in place to obtain regular updates to check their continued suitability. We raised this with the home manager who told us they would introduce an annual declaration to be signed by each staff member confirming they had not been involved in any criminal activity. This meant people could not be assured that staff continued to be of good character.

We recommend the provider seeks advice and guidance about ensuring staff continue to be suitable for the job.

People and relatives felt there were enough staff on duty to meet people's needs. One person told us, "There's no waiting for ages after you press the buzzer – someone is here right away." Another person told us, "There is enough staff." A relative said, "There's always someone who knows my relative and that is very reassuring." Another relative told us, "It's quieter at the weekends, but there are still enough [staff] around."

The manager and staff told us the service did not use agency staff but used bank staff who were permanently employed by the service to cover staff absences. One staff member told us, "[There's] always enough staff." Another staff member said, "We have enough staff on duty. When I need staff, I make a request to the manager and she always tries to get me staff."

During our inspection, we observed staff were not rushed and were able to spend time conversing with people. There were enough staff on duty to ensure each person was checked at least once an hour. Staff rotas showed the service had 15 care assistants and four nurses on duty during the day and four nurses and five care assistants on duty at night. This meant there were enough staff on duty to meet people's needs.

The provider had a comprehensive medicines policy which included clear guidelines to staff about ordering, receiving and storing medicines, administration of medicines and record-keeping. People's medicines were stored in locked cabinets in a locked room on each floor. Medicine fridge temperatures were checked daily and were within the correct range. Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had effective systems in place to ensure controlled drugs were stored appropriately and correctly accounted for in line with current legislation.

People who required their medicines to be given covertly had guidelines on how to safely administer the

medicine and signed agreement by the GP. Covert medicines are those that need to be given in a disguised format because the person lacks the capacity to understand why the medicine is needed.

Medicine administration record (MAR) sheets had been completed and signed with no gaps to indicate people had received their medicines as prescribed. However, we found one instance on one floor where the MAR sheet had been signed for a tablet for one person the morning of the inspection but the medicine was still inside the blister pack. The nurse in charge raised this as an incident to pass onto the manager to look into.

People who required 'pro re nata' medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. Reasons for giving PRN medicines were documented on the back of the MAR charts. PRN medicines that were not supplied in blister packs were in date and clearly labelled. However, we found for one person's PRN medicine the amount recorded in the stock count was different to the amount contained in the box. The nurse in charge raised this as an incident to pass onto the manager to look into.

The provider had systems in place to ensure medicines issues or errors were identified and resolved in a timely manner. A nurse told us, "Whoever administers medicines has to complete a daily medicines checklist which includes looking at any gaps, signed for but not given medicines, total medicines remaining and any missing or broken medicines." Records showed this was the case. The provider also carried out monthly medicine audits which included identifying gaps in MAR sheets and whether the total numbers of medicines remaining were accurate. This meant the provider had systems in place to manage medicines safely.

One person told us, "I find it very clean, even my son comments on it." Another person said, "100%, they are always cleaning," A third person told us, "The cleaners are here all the time doing something." A relative said, "The place never smells badly like some care homes do."

The provider had an infection control policy which gave guidance to staff about the steps they should take to prevent the spread of infection. A staff member told us, "Always enough stock of protective gloves and aprons. After cleaning someone, always take gloves off and apron before entering back into the corridor." The service had adequate hand washing facilities which included hand soap and gel. The head chef told us, "We have our daily cleaning, which includes drawers, trolleys and we have a deep cleaning schedule every day. We do daily cleaning every day." This meant the provider had systems in place to protect people from the spread of infection.

The provider had a system of recording accidents and incidents which included documenting if first aid was needed or a hospital admission. The home manager gave an example of how the service learnt lessons from incidents. A person had been in the home for one year and was admitted to hospital with a chest infection where they passed away. Following this incident a visit to the home was arranged for infection control procedures to be audited. The outcome of this audit was a recommendation for the service to evidence that basic infection control procedures are in place when a person has an infection. The service introduced an infection prevention and control and hand wash audit to be undertaken every three months. The service also introduced a monitoring tool to be used when a person had a suspected infection.

Good

Is the service effective?

Our findings

Care records showed that people had an assessment of their care needs before they began to use the service. Assessments were comprehensive and included information about relationships, communication, mobility, religious, spiritual and social needs, medical history and level of assistance needed. For example, one person's pre-admission assessment included, "[Person] has five children. [Person] likes music and dancing. Seen dancing to music playing in the garden. Allergic to penicillin." This meant that people's needs were assessed and important information about the person could be captured before they began to use the service to ensure the service could meet their needs.

People and their relatives told us they thought staff had the skills needed to provide care. One person told us, "You get constant and consistent care." Another person said, "I do think the staff have the right skills." A third person told us, "They are all great at what they do." A relative told us, "I can tell they have the right skills by the way they talk to people." Another relative said, "I've never seen my relative in a situation that I'm not happy with." A third relative told us, "The staff have common sense and know what needs doing, it's very reassuring."

Staff confirmed they had regular opportunities for training. One staff member told us, "I had an induction. We are well trained. We have ongoing training. Training is good quality." Another staff member said, "The manager is very good at letting us know the training available and also when we need updating. I have all the training I require to do the job."

New staff completed an induction programme in the core topics of care and shadowed experienced staff. Training records showed the training nursing staff received included the management of respiratory conditions, awareness of acquired brain injury or stroke, catheter management, diabetes insulin administration, care planning and risk assessment. The training matrix showed when staff were due for refresher training and showed staff had received safety related training including moving and handling and fire safety. This meant people received care from suitably skilled and qualified staff.

The provider supported staff to do their jobs through regular supervisions and appraisals. Staff confirmed this and told us they found these meetings useful. One staff member told us, "I have supervision. Supervision is like six weekly. We discuss infection control, how we deal with residents, customer service, resident families." Another staff member said, "I have supervision monthly and appraisal annually. I can meet the clinical manager anytime for discussion and advice."

Records showed staff received regular supervision in accordance with the provider's policy. Topics discussed in supervisions included care plans, training, medicines, monitoring of food and fluid intake, identifying symptoms of constipation and urinary tract infections. Staff were also supported with annual appraisals which looked at the staff member's performance over the last year and areas for improvement.

People and relatives told us they enjoyed the food. One person told us, "It's always something lovely, my son is a butcher and he was amazed at the quality of the meat." Another person said, "The food is okay. I don't

expect anything fantastic." People could choose to have their main meal at lunchtime or teatime. However, people told us they would like an alternative to sandwiches every day. We discussed this with the manager who told us they were in the process of devising new menus and the chef was speaking to individuals to find out their preferences.

A relative told us, "My husband doesn't eat a lot, but it's always a good meal." Another relative said, "I know what she was like before. Her skin looks so well nourished. She can't eat normally but they liquidise all her food. It looks nutritious and she hasn't lost any weight." A person's friend told us, "The food is well presented. The food always smells nice. Sometimes I feel like having the meal myself. [Person] eats the food all the time. This is a good sign that the food is nice."

One staff member told us, "I always ask people what they want to eat and give choices. If they want anything specific they will get it. I support people with feeding. Give them time to swallow. Never force feed." Another staff member said, "We have variety, for example African and Caribbean options. We have different cultures. If they refuse, we will go and buy them whatever they like if they want it from outside."

During the inspection we observed lunch being served. People chose different options from the menu and the food was well presented and in a timely manner. A choice of drinks and desserts were offered. There was a relaxed atmosphere during lunch with staff smiling and making jokes. People who needed assistance to eat were supported by staff at their own pace and with the staff member sat beside them. We observed very little food was left on the plates after lunch which indicated people enjoyed the meal. This meant people were supported to maintain their nutrition and hydration needs.

The service worked jointly with healthcare professionals to ensure people's healthcare needs were met. Care records contained a record of health professional visits and the outcome of appointments. For example, people had access to the GP, psychiatry, physiotherapy, speech and language therapy, dietitian and optician as needed. A visiting healthcare professional told us, "I have found the staff very helpful. I wish other places were like this. They carry out the care to the letter and when I come here I always find somebody who is both helpful and knowledgeable about the [person using the service]. They have been very good at implementing the plans."

People had healthcare guidelines for specific health conditions. However, we noted generic diabetic guidelines were used for people with diabetes who were nil by mouth and received their nutrition through a percutaneous endoscopic gastrostomy (PEG) feeding tube. We raised this with the manager and asked if the remedies suggested in the guidelines for people suffering from hypoglycaemia (low blood sugar) would be suitable for people who were nil by mouth. The manager took immediate action and sought advice from the GP and Diabetes Nurse. The outcome of this was a hypoglycaemia kit consisting of glucose juice was introduced for people who were nil by mouth which would be administered by the PEG tube. The guidelines for diabetics who were nil by mouth were updated to reflect this.

The building was purpose built and laid out across four floors accessible by lift. The home contained a hair dressing salon, a library, a games and exercise room, a sensory room, a pub room, a coffee room and a movie room. Each bedroom contained an ensuite toilet and hand basin. The home also had pet rabbits and a cat which people could stroke or interact with. There was a covered area in the garden where people could go to smoke and be sheltered from the weather. This meant the building was adapted to meet people's needs.

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 this inspection there were 56 people with legally authorised DoLS and 32 people awaiting a decision because they required a level of supervision that may amount to their liberty being deprived. Care records showed assessments and decision-making processes had been followed correctly.

Staff understood the need to obtain consent before delivering care. One staff member told us, "Never force anybody. Give them time. People might refuse medicine and food. We leave them for a while and go back and quite often they will take it. During personal care, we always let the person know what we are doing." Another staff member said, "Whatever we want to do with [people using the service], we have to ask their permission. You have to talk to them. Some will use facial expression, some will use body language [to give consent] so we know." This meant the provider and staff worked within the requirements of legislation.

Good

Is the service caring?

Our findings

Comments from people using the service included, "It's very amusing here, I love it. They really are very kind", "This place is really, really caring" and "The whole place and manner of the staff really puts you at ease. There's a lovely warm sense of humour too." A relative told us, "It's really helpful that they have the same of team of people caring. The familiarity for people living with dementia is very important." Another relative said, "It's how people are talked to and looked after, they make everyone feel so special. They even make the family feel welcome." A third relative told us, "It's a nice atmosphere, it's an advert for good care for people living with dementia."

Staff told us how they developed caring relationships with people who used the service. One staff member told us, "Through the paperwork from wherever they are coming from which explains who they are and everything about them. Try to observe the person by talking to them. Try to calm them down and say everything will be alright." Another staff member said, "We get to know people when we go and assess them before they come here. When they come here, we introduce ourselves to them. We have a lot of information about them. The best way is when they are here and you interact with them. You find out about them by talking, listening, observing and talking to their friends and relatives."

Throughout the inspection there was a calm atmosphere and staff took the time to talk to people. A staff member told us, "I like to look after [people]. I enjoy working with older people and I enjoy seeing that I can help people." Another staff member said, "I deal with people like they are my family. You have to treat people how you would want to be treated and how you would want your family to be treated." This meant people received their care from caring staff.

Relatives gave positive feedback about communication from the service. A relative told us, "The nurses keep us informed of everything, they come and find us and contact by phone or email, they feedback all the time." Another relative told us, "I am involved in the care planning as the next of kin. It's reviewed formally every six months."

Staff explained how they involved people and families in the care. One staff member told us, "We always involve people and relatives in all aspects of care. We use this information when we plan care." Another staff member said, "We involve people in their care and invite the relatives to contribute to their care. We always involve people in the way they like things." This meant people and their relatives were involved in discussions about the care provided.

Each person had a named nurse and a keyworker. The named nurses took responsibility for record keeping. The keyworker was allocated to the person according to ethnicity, language or religion. A keyworker is a named care worker who has responsibility for overseeing the care a person receives. At Acorn Lodge Care Centre, the keyworker liaised with the person they were allocated to and their family in addition to ensuring the person has the clothing, nailcare and hairdressing they require.

The provider had an equality and diversity policy which gave clear guidance to staff about equality and

diversity. Staff were knowledgeable about providing an equitable service. One staff member told us, "We have quite a mixture of cultures here. Because of different backgrounds, different families come here and want different things. No discrimination. We don't discriminate [against] no-one here." Another staff member said, "We have different backgrounds [in the home] and we try to work in their best interests."

We asked staff how they would support somebody who identified as being lesbian, gay, bisexual or transgender (LGBT). One staff member told us, "No discrimination. We take information about people's gender and sexuality and ensure that they remain confidential. We give care according to people's preference and choice. People can choose the [gender] of staff they want to care for them. We don't have any LGBT [people living] here at the moment." Another staff member said, "We would be friendly with them. They have the right to ask for whatever they want. We talk to them, not isolate them." A third staff member told us, "I would try to treat them the same with respect and dignity." This meant staff were knowledgeable about equality and diversity.

People and relatives confirmed privacy and dignity was promoted. One person told us, "They do respect my privacy. They involve me but never push me to do things that I don't want to do." Another person said, "They do respect my privacy. They close the door and ask permission to help me too." A relative told us, "I've noticed they respect my [family member's] privacy. Closing doors and asking relatives to leave while personal care is being given is second nature to the staff."

Staff explained how they promoted people's privacy and dignity. One staff member told us, "You don't go around and discuss their business with others. Knocking on the door, identifying yourself, tell them what you are going to do, close the curtains and the doors." Another staff member said, "We call them by their preferred name. We knock on the door before going in their rooms. We ask them how they would like things done." A third staff member told us, "When we go to their room when delivering personal care, we close the door, draw their curtains and give them a choice of clothing." This meant people's privacy and dignity was promoted.

People and relatives told us their independence was encouraged. One person told us, "They do help me keep what independence that I have, for example, I do some washing myself. I know they would give me more help if I needed it." A relative said, "My relative isn't able to do anything for herself but they do always ask her permission and I think that in a way is promoting independence."

One staff member told us, "We encourage those who can still do things for themselves, for example, choosing own clothes, washing hands. It's not about taking independence away from people." Another staff member said, "We always encourage people to do things for themselves." A third staff member told us, "By encouraging [people] every day to be independent. We can encourage [a person] by walking them around using a zimmer frame and walking with them to support them." This meant staff knew the importance of promoting people's independence.

Good

Is the service responsive?

Our findings

Relatives told us their family member's needs and wishes were promoted. One relative told us, "My [family member] always likes to wear a t-shirt and they know this so he feels comfortable." Another relative said, "All [family member's] wishes are catered for. They are very good at finding out what she likes."

Staff demonstrated they understood what personalised care was. One staff member told us, "It means individual care. It's quite different from everyone's care. What Mr A wants is quite different from Mr B." Another staff member said, "It is about doing things like the person likes it and involving others who know the person with their permission." A third staff member told us, "[Personalised care] is individualised care. Respecting people's wishes."

People's care plans were comprehensive, personalised, and contained people's history and preferences. For example, one person's care plan stated, "[Person] loves a cup of tea with meals." Another person's care plan stated, "Enjoys eggs but not full cooked breakfast. Dislikes spicy food." Care records indicated how each person liked to be addressed and prompted staff to, "Explain what you are about to do to [person]." Records showed how much support the person needed for each aspect of care. People's care plans included personal care, continence, eating and drinking, mobility and behaviour. One person's care plan stated, "[Person] prefers to have a strip wash in the morning, is not an early bird, does not wish to have [a] wash early morning." This meant people's preferences and choices were met.

The manager explained to us how they were meeting the Accessible Information Standard (AIS). The AIS requires providers to evidence that they record, flag and meet the accessible communication needs of people using the service. The manager told us, "We have communication aid books with pictures in. Nobody needs this at the moment. We use pictures for reminiscence and do a newspaper group. We have pictorial menus."

We asked the manager how they ensured that people with a sight impairment had access to written information. The manager told us, "The community library comes every week and they will visit the [person] to make sure they have audio books or braille. Always make sure staff announce themselves and say who they are." We asked the manager how the service made sure people had access to spoken communication if they had a hearing impairment. The manager told us, "We have a system in place. The first is to refer to [the GP] to make sure there is no wax build up. If that hasn't helped we will do a referral to audiology to do moulds for hearing aids." This meant people's communication needs were met.

People and relatives told us activities were available. One person told us, "They come to the bedside and help me to exercise." Another person said, "They do have a programme of activities, but I like to go out on my own. If I need to go out early, they are flexible and will get me ready earlier." A relative told us, "My relative can't participate in the activities. I'm not sure what understanding she has. There are events and she is taken down to them, it's unclear how much enjoyment she gets but it's great she has a change of scene for a few hours" Another relative said, "They make a special fuss when it's a birthday and do something they enjoy."

The service had an activities co-ordinator and was in the process of recruiting a second staff member for activities. Records showed the variety of activities offered on a weekly basis included a newspaper delivery, hairdressing, pampering, sensory group, music therapy, aromatherapy, music quiz, karaoke, film group, chair-based exercise, arts and crafts, creative snacks group, small group activities and sporting events. One-to-one activities were offered four mornings and three afternoons a week to people who chose to stay in their rooms.

During the inspection we saw a group of people went on a trip to a local park. Monthly activities included Caribbean hairdressing and late-night pub event. The service also had a seasonal activities programme. For example, the summer programme included barbecues, themed days, guest entertainers and a trip to London zoo. The home manager told us that the pub room was available to families to celebrate family occasions and birthdays. This meant activities were offered to maintain people's well-being.

People and their relatives told us they knew how to make a complaint. One person told us, "I've no complaint. It's really really nice but you can talk to anyone if you wanted." Another person said, "There's a user forum meeting that I do go to. It's a comfortable and easy place to raise things which aren't immediate issues." A third person told us, "I've been here seven years and I have no complaint what so ever." A relative said, "My husband has been here a year and there's never been any reason to complain." Another relative told us, "If there's a little problem, it's done and sorted but there's only ever little things, for example, lost slippers, a light switch not working. The maintenance man was called right away, and it was fixed. You don't have to hang about getting frustrated because nothing happens."

The provider had a complaints policy which gave clear guidance to staff, people using the service and their representatives about how complaints would be handled. The home manager showed us the complaints procedure was available in an easy read pictorial format to make the process easier to understand for people with learning disabilities or dementia.

Records showed complaints were dealt with appropriately and within the provider's timescales. For example, one person was supported by the manager to complain about the cleaning not being to an acceptable standard. The action taken was noted as, "Additional monitoring after hours. All staff aware."

The provider also kept a record of compliments. We saw three written compliments were made by relatives. For example, a relative stated, "[Staff] are extremely attentive and communication between them are excellent." Another relative stated, "Very happy with the service." The third relative stated, "Thank you so much for all your support and kindness and caring." This meant the provider had a system to use complaints and compliments to improve the service provided.

People had advanced care plans which indicated their wishes about where they would like to spend their last days, who they wanted to be notified, any religious considerations, whether there was a will or a funeral plan and their funeral wishes. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were in place for people who did not wish to be resuscitated if they had a cardiac arrest or were to die suddenly. Decision forms had been signed by the GP and showed a discussion was had with the family. Where people had capacity, they had signed the DNACPR form.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager. We raised this with the home manager who was also the 'nominated individual'. A nominated individual is a person who has the responsibility for supervising the management of the regulated activity. The home manager told us they did not realise they were not the registered manager and would start the process of becoming registered.

This was a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009 because the service was required to have a registered manager in position.

Relatives gave positive feedback about the management of the service. A relative told us, "They are very approachable and as [manager] always says, 'tell me the little things to stop them getting any bigger'." Another relative said, "There's no guardedness. They are confident about the quality of the care. They encourage you to drop in at any time. There's nothing to hide." A third relative said, "It's [the manager]. She knows what she is doing. She has an energy and a good practice."

Staff gave positive feedback about the management of the service. One staff member told us, "I couldn't ask for a better manager. The manager loves the staff and loves the [people who use the service]. She's lovely." Another staff member said, "I'm proud to work here. Good staff and management. There's a clear understanding of what's expected of us." A third staff member said, "The manager is very good and I can talk to her anytime. She is a good listener and very kind. She cares for the people and staff."

The manager told us they had a conversation with all new staff to check how they were and if they were being treated with respect by other staff. The manager also told us, "You have seen my staff. They have no problem. We have an open-door policy and I am very visible. Whenever I do my rounds I will ask them if they are ok and what they plan for the day. I am the clinical lead. If they really want to, they write a note and push it under my door."

Staff confirmed that staff from different ethnic and belief groups were treated equally and there was no discrimination. One staff member told us, "Everybody here is treated as an individual and respected." The manager gave an example of one member of staff who was gay and had issues with another member of staff who was not tolerant of homosexuality due to religious reasons and explained how she successfully dealt with this.

The provider carried out a feedback survey in November each year. The home manager told us the survey could be converted to a pictorial format or could be done face to face if needed but at the moment there was no need. We reviewed the most recent evaluation carried out for the feedback received from relatives in 2017 and saw that 92% of respondents were satisfied with the quality of the care. Actions had been taken appropriately in response to the feedback. For example, records showed that the four-weekly cycle of activities had been reviewed and the themed rooms integrated into the programme. We also saw the results of the annual survey of people using the service showed people enjoyed eating Caribbean food, so this was to be implemented two or three times a week. Records showed this was currently the case.

People who used the service had monthly meetings and records confirmed this. Topics for discussion included care, food and activities. Feedback from people who used the service during these meetings were positive and comments included, "Happy with care", "Yes, all ok. Happy with the [staff] that look after me" and "The food is lovely but I would like more fish and chips." The home manager told us, "There is an open-door policy for the relatives. We have a lot of email contact. Relatives' meetings are poorly attended because relatives can come in at any time. They are invited to all functions and they do attend." This meant the provider had a system to obtain the views and suggestions of people who used the service about the quality of care delivery.

Staff meetings took place monthly with the agenda discussions including teamwork, taking breaks, answering call bells, staff punctuality, annual leave and communication. Records showed these meetings were up to date. Staff confirmed they found the meetings useful. One staff member told us, "If you have anything on your mind it is where you can explain yourself. Everybody will sit down and we talk." Another staff member said, "You hear other opinions and you can get to know other ways of working." This meant staff were updated on service development and were able to have their views heard.

The provider had several systems of monitoring the quality of the service provided which could be used to improve the quality of care delivered. An annual home audit was completed in December 2017 which including checking on care planning, medicines, infection control and risk management. Records showed no issues were identified.

The manager had carried out an infection prevention and control and hand hygiene management audit on 20 July 2018 with no issues identified. Records showed a monthly monitoring comparison was carried out which included new admissions, hospital discharges, people admitted with pressure wounds and people with catheters.

The service worked jointly with other agencies. The manager told us they were involved in a pilot study with the community team consisting of the dietitian and the speech and language therapist. The outcome of this study was there was now a step by step guide of fortification to follow before putting in a referral for somebody who was losing weight and this included implementing a food and fluid chart, fortifying foods and weighing weekly. The manager also attended provider forum meetings to share examples of good practice.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The home manager was not registered with CQC to provide the regulated activities.