Care UK Community Partnerships Ltd

Franklin House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 and 9 December 2015 and was unannounced.

The last inspection of the service was 17 July 2014 where we found there were no breaches of Regulation.

Franklin House is a nursing home for up to 66 older people managed by Care UK Community Partnerships Limited. At the time of the inspection 63 people were living at the service. Some people were living with dementia, others had general nursing needs and some people were being cared for at the end of their lives.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

We found one breach of the Regulations. We witnessed a number of interactions where the staff did not treat people with respect. However, the majority of staff were kind and caring towards people. People living at the home and their visitors told us the staff were caring and they had positive relationships with them.

People's privacy was respected.

Risks to people's well-being were identified, assessed and managed.

There were appropriate procedures to keep people safe and the staff were aware of these.

People received their medicines in a safe way which met their needs.

There were enough staff employed and the procedures to recruit them were suitable.

The environment was safely maintained and clean.

People's capacity to make decisions had been assessed and their consent to care and treatment was recorded.

The staff had the training and support they needed to care for people and meet their needs.

The environment had been adapted to include features which added interest and helped orientate the people living there.

People's healthcare needs had been assessed, monitored and met.

People were offered a variety of freshly prepared food. Their individual nutritional needs had been assessed and care was provided to meet these.

People's privacy was respected.

People's care was assessed and planned to meet their individual needs.

There was a programme of organised social activities and resources available for people to entertain themselves if they wished to use these.

There was an appropriate complaints procedure and people felt able to raise concerns.
People living at the home and the staff felt there was a positive culture at the home. They found the manager approachable.

People were given opportunities to contribute their views to the way in which the service was run.

There was an effective system of audits and monitoring to ensure people's needs were safely met, risks were managed and the service was continuingly improving.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people's well-being were identified, assessed and managed.

There were appropriate procedures to keep people safe and the staff were aware of these.

People received their medicines in a safe way which met their needs.

There were enough staff employed and the procedures to recruit them were suitable.

The environment was safely maintained and clean.

Is the service effective?

Good

The service was effective.

People's capacity to make decisions had been assessed and their consent to care and treatment was recorded.

The staff had the training and support they needed to care for people and meet their needs.

The environment had been adapted to include features which added interest and helped orientate the people living there.

People's healthcare needs had been assessed, monitored and met.

People were offered a variety of freshly prepared food. Their individual nutritional needs had been assessed and care was provided to meet these.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

We witnessed a number of interactions where the staff did not treat people with respect.

However, the majority of staff were kind and caring towards people. People living at the home and their visitors told us the staff were caring and they had positive relationships with them.

People's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People's care was assessed and planned to meet their individual needs.

There was a programme of organised social activities and resources available for people to entertain themselves if they wished to use these.

There was an appropriate complaints procedure and people felt able to raise concerns.

Is the service well-led?

Good

The service was well-led.

People living at the home and the staff felt there was a positive culture at the home. They found the manager approachable.

People were given opportunities to contribute their views to the way in which the service was run.

There was an effective system of audits and monitoring to ensure people's needs were safely met, risks were managed and the service was continuingly improving.

Franklin House

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 8 and 9 December 2015 and was unannounced.

The inspection team on 8 December 2015 consisted of three inspectors, a nurse specialist 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. The expert-by-experience on this inspection had personal experience of caring for someone who used care services. The inspection on 9 December 2015 was conducted by a pharmacy inspector.

Before we visited the home we looked at all the information we had about the service. This included the last inspection report, notifications of significant events and safeguarding alerts.

During our inspection we spoke with 12 people who lived at the service, 13 of their visitors, three healthcare professionals who were visiting the service on that day and the staff on duty, who included the registered manager, deputy manager, nurses, healthcare assistants, domestic and catering staff and the regional director. We looked at care records for 29 people, staff recruitment records for five members of staff, staff training and supervision records and the provider's records of quality monitoring, audits and complaints. We also looked at the records, storage and administration of medicines.

Good

Is the service safe?

Our findings

People told us they felt safe at the service.

We observed one incident where a person could have been put at risk because of the way in which they were being supported. This occurred at lunch time when a member of staff did not sufficiently check that a person had swallowed their food before offering them additional mouthfuls. The person also shook their head indicating they did not want to eat and the staff member ignored this holding a spoonful of food to the person's mouth. However, the nurse in charge of the unit responded by stopping the member of staff. They also took the person away from the dining room and checked their vital signs and wellbeing following the incident. We made the manager aware of the incident and they told us they would be speaking with the member of staff concerned and retraining in this. The deputy manager and manager had created guidelines regarding eating and drinking and swallowing difficulties. These included information from relevant professionals. These were available on each floor of the home but some staff were not aware of them. The manager told us that they would be redistributed and discussed with all staff following the inspection visit.

The risks to people had been assessed. These included the risks of using equipment, nutritional risk and risk of developing pressure sores. The assessments were clear, reflected individual needs and specific risks to the person and gave information about how staff should support people to stay safe. The staff updated these assessments monthly and following changes in people's needs. The staff demonstrated a good knowledge of individual risks and how these should be managed. There was evidence that equipment used to keep people safe was regularly checked by the staff.

The provider had a suitable procedure for safeguarding vulnerable people. The staff were aware of this and were able to tell us what they would do if they suspected someone was being abused or at risk of abuse. There was evidence the staff had received relevant training. Records of staff meetings and supervisions showed that the safeguarding and whistle blowing procedures were discussed and the staff had opportunities to discuss different scenarios. There was information on display around the building to show what action people should take if they were concerned about someone's safety. The staff wore identity badges with their name and designation on so they could be easily identified. The provider had followed procedures when safeguarding alerts had been made. These included notifying the Care Quality Commission and local safeguarding authority of concerns. There was evidence that they had investigated allegations and of the action taken, which included changing practices to keep people safe.

The environment was clean and well maintained. People told us this was always the case. One visitor said, ''the home always smells fresh and clean.'' The provider undertook regular checks of infection control, cleanliness and maintenance. Repairs were attended to promptly and records showed this. The provider's record of checks showed that equipment was safe to use. There were up to date checks on firesafety, electricity, water and gas safety. The fire risk assessment was up to date and there was information about the support each individual needed in event of a fire. The staff had been suitably trained and had a good knowledge of what to do in event of a fire or another emergency. There were emergency protocols and

information about different services was clearly recorded so the staff could access this if needed. There was information about infection control and hand hygiene displayed around the home. The provider had recently installed new and improved lighting in corridors and stairways. They were in the process of redecorating communal corridors. This was being safely managed in a way to cause minimum disruption to people and staff working at the service. Emergency equipment was situated throughout the home, such as first aid supplies and fire equipment. These were clearly signposted and staff knew how to use them.

People told us that there were staff available to meet their needs. One person told us they sometimes had to wait a long time for support. Another person told us, "here you sometimes have to ring the call bell 4 or 5 times before they come.'' However, other people told us call bells were answered promptly and that their needs were mostly met in a timely manner. One person said, "it might take a few minute (to answer the call bell) but I don't expect them to come straight away." A visitor told us, "they pop in every half hour because he doesn't use the call bell." The manager told us staffing levels had been reviewed and increased in 2014. Some of the things people told us were, 'there were a lot of agency staff a while back but things are better now'', ''staff are always available'', ''they are very quick to come and see me'' and ''I never have to wait long if I need help.''

Some of the staff told us they did not think enough staff were employed to support people. They said that during some of the busiest times of the day people had to wait for care. They gave examples that many people required the support of two members of staff to move safely from one place to another. They said that sometimes only four members of staff were employed on one unit and this meant they could only support two people at one time. The majority of people living at the home did have needs which sometimes required more than one member of staff. However during our inspection we saw that people's needs were being met and the staff were deployed in a way which meant people did not have to wait long for care. There was a large amount of staff visible and available as people needed them.

There had been a high number of staff vacancies at the service. This had resulted in the provider employing a large number of agency (temporary) staff. This had impacted on the consistency of care and some agency staff were not familiar with the home and people's needs had sometimes not been met promptly as a result of this. However, the manager told us they had successfully recruited permanent staff and that they were still interviewing and recruiting more permanent staff. The number of agency staff hours used at the home had significantly reduced. This meant that people were receiving more consistent care from staff who knew their needs. Although, because the home had not recruited all the staff they needed at the time of the inspection, the service was still employing some temporary staff.

One staff member told us the lack of permanent staff had affected morale at the home and this had impacted on the care people received. However, other staff told us they felt the situation had improved. We met a number of staff who had been employed in 2015. Some of them had previously worked at the service, but had left to work elsewhere. They told us they were happy to be back working at Franklin House. The manager had actively recruited staff who he had known from previous employment and they were suitably skilled and experienced.

One visiting professional told us they visited the home on a regular basis. They said, "I never hear anybody calling out for help and not receiving it."

In addition to the nursing and care staff, the provider had nurse students on placement at the service who were providing additional care and support. The manager told us they had reviewed how staff were deployed at certain times of the day. This included catering and domestic staff offering support to people at mealtimes if needed. They had received appropriate training to do this.

There were appropriate procedures for the recruitment of staff. These included making checks on their suitability, such as criminal record checks, their identity, references from previous employers, registration pin numbers for nurses and eligibility to work in the UK. All staff were invited for a formal interview at the service and were employed on a probationary basis. We saw records of the checks and other information relating to staff recruitment.

The provider followed the relevant professional guidance about the management and review of medicines. For example, we saw evidence of a yearly audit carried out by the supplying pharmacy and local CCG pharmacy team. These showed good governance processes as they fed back into a system of reporting improvements to the provision of medicines.

People received their medicines as prescribed, including controlled drugs. We looked at 18 Medicines Administration Records (MAR) and found no discrepancies in the recording of medicines administered. This was confirmed with one person who reported that they received their medicines in a timely and correct manner. We observed the staff administer medicines in a safe, caring and effective manner. We also observed the staff administer pain medicine to a person in-between a normal medicines round, which meant that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them.

Medicines were stored and locked away appropriately in the treatment rooms. However, we found one instance where a person's opened insulin pen was stored in the fridge. This meant that this particular aspect was not in line with current and relevant guidelines. This was fed-back to the manager who immediately rectified the situation. Medicines which needed to be disposed of were placed in the appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by the local community pharmacy contractor.

We found two people were administered medicines covertly (without their knowledge). These were done in line with the Mental Capacity Act 2005. We saw evidence of a Mental Capacity Assessment and Best Interest Meeting form within the MAR folder, with clear procedures documented in the plan about the practicalities of administration. The appropriate document had been updated within the last three months and signed by a relative, clinicians and the community pharmacist.

We saw 13 PRN forms for pain-relief medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit.

The manager informed us that no one was currently self-administrating their medicines, and that if homely remedies had been administered, this was recorded on the MAR (as stated in the medicines management policy). We found evidence of this for one person. We also saw evidence of appropriate monitoring associated with the use of medicines. For example, we saw blood glucose recordings for people who had diabetes. We also saw pulse readings for people who took certain steroid medicines. We saw a patch rotation site record for one person who was taking a pain relief medicine via patches. These forms assured us that people were protected against the risk of medicines related harm.

Good

Is the service effective?

Our findings

We observed the staff obtaining people's verbal consent when they offered them support.

The provider had undertaken assessments of each person's mental capacity and ability to make different decisions about their care. These assessments were recorded and incorporated into their care plans. There were assessments for individual decisions, such as the use of bedrails. The manager told us that some assessments were not completed at the time of the inspection and we saw that these were still being carried out.

We looked at how capacity was assessed and consent to care recorded in 15 care records. Where people were considered unable to consent, a decision to provide care had been made in their best interest by the staff, other professionals and the person's representative, or next of kin. There was a record of consent to the care plan (or best interest decision) in 13 of these, but no record of consent in two of the files we looked at. Six people had consented to their own care and treatment, whilst seven people had been assessed as not having the capacity to consent. Their next of kin had been consulted and had signed agreement to the care plan. In some, but not all files looked at, the person or their next of kin had signed an agreement for the use of bedrails.

The manager told us they had audited all care plans and had arranged to discuss these with the next of kin for each person. They had a record of the people who still needed to be consulted to ensure the person's consent or the next of kin's agreement to a best interest decision was recorded. The manager said that in all cases non recorded consent had been given, however the records required updating to confirm this. People and their relatives told us that this was the case and they had been asked for their agreement to the care plan.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager was aware of their responsibilities under this legislation. For example, some people were restricted from leaving the home on their own because it was considered unsafe for them to do so. The provider had started to make applications to restrict people's liberties to the appropriate authorities. The manager told us they were waiting for the authorisation for these. Other DoLS had been identified and the manager had started the process of applying for these, although these had not been completed at the time of the inspection.

Eleven of the care records we looked at included a Do Not Attempt Resuscitation (DNAR)form stating the person did not wish to be resuscitated in the event that their heart stopped. These forms had been photocopied and information recorded on them was not always clear. For example, the forms included a section to evidence discussion with the person or their next of kin. This information was sometimes illegible. The forms had been signed by the person, or their representative and the person's GP. However in three

cases the person had been assessed as having capacity to make this decision but there was no evidence of consultation with them on the form. The information recorded in people's care plans was not always reflected in the use of these forms, or information was unclear about the person's wishes. For example, one care plan stated the person did not wish to discuss what would happen in this case, they had been assessed as having capacity but the staff had said a DNAR form was necessary. Although a DNAR form was not in place, the information was unclear and there was a risk that the person's wishes would not be followed. We fed this information back to the manager who agreed to undertake an audit of all DNAR forms and associated care plans to make sure they were recorded correctly, were clear and included consistent information about the person's wishes.

The staff told us they felt supported and had the training and information they needed to undertake their roles. Care UK provided a range of training for staff when they started work at the service. This included manual handling, safeguarding adults, fire safety, health and safety and infection control. The manager and three other senior staff were qualified trainers and provided in house training and support for new staff. The deputy manager was a nurse and she supported the nursing staff to keep their clinical training and knowledge updated. For example, the nurses had recently undertaken training in end of life care, wound care and diabetes. The staff undertook some training via e-learning. The manager had systems to assess when training refreshers were due. They told us that some staff needed to update some aspects of their training and this had been organised.

The staff told us they had regular individual and team meetings with their manager. They said they felt they had opportunities to discuss their work. Some of the things the staff told us were, ''everybody works as a team'', ''we support each other and everyone is respected'' and ''the managers are available for us to speak to if we need them.'' Minutes of team and individual meetings showed that different procedures were discussed. The manager organised for meetings with different departments, including a weekly heads of department meeting, a weekly clinical meeting and a health and safety meeting. The records of these indicated that the individual needs of people, changes to the service and plans for improvement were discussed.

The manager told us that individual supervision meetings had not happened as often as they were needed. They showed us a plan which had been shared with all the senior staff at the service telling them when they should provide supervision and support to each member of staff. The provider had introduced a new system of appraisal and the manager said that they would be undertaking annual appraisals for all staff early in 2016.

The provider had added features to the home to promote a dementia friendly and interesting environment. Communal rooms and corridors were themed and interactive, For example, one part of the home had information about local history and photographs on display. Other themes included sewing and needlework, the beach, sports, transport and war time history. There was also a music room. The corridors featured tactile pictures and displays which could be played with or moved. There were fabric murals and pictures with detachable features. There were also a large amount of ornaments, books, blankets, toys, dolls, clothes and other equipment around the home. The manager told us people were able to help themselves to whatever they wanted and take items around the home and to their rooms if they wished. He said that the equipment was there for people to use and enjoy as they wanted. The staff spoke with people about particular themes they would like and this was reflected in the various displays. The lounges included accessible equipment which people were encouraged to help themselves to. Each part of the building had different features to help orientate people and also to provide different stimulation and interests.

The home was decorated for Christmas throughout the building. The staff had decorated to different colour

schemes throughout the house and the decorations looked new and attractive.

There was information and guidance on display throughout the home, including details of the home's complaints procedure, information about activities and booklets about the local area.

The majority of people told us they liked the food at the home. They said it was well prepared and they were able to make choices. Some of the things people told us were, ''the food is good and I get a choice'', ''(my relative) has enough to eat and the staff cut it up for her'', ''I enjoy the food here'', "the food is not at all bad, I had a cooked breakfast this morning, it was very nice; you get it (a cooked breakfast) if you ask for it, otherwise you get porridge, which is very nice", "I'm quite happy with the food, we could do with a bit more fresh food eg salads'', "the food is well done" and "(my relative) likes the food, she's putting on weight."

We observed breakfast and lunch being served at the home. The food was freshly prepared, hot and people were able to make choices about what they ate. Alternatives to the main menu choices were also available and offered to people.

The chef and catering staff had a good knowledge of individual needs and preferences. They spent time talking with people and observed meal times to gain feedback about the food. Menus were well advertised and people were able to make choices outside of the menu. The catering staff were employed until 8pm each night and offered freshly prepared and hot food until this time. Sandwiches and other food were available at night. We saw people were able to have a variety of hot and cold drinks throughout the day. Cakes and fresh fruit were offered during the afternoon.

The chef had a book for people living at the home and their visitors to comment on the food. They said they used this to help them plan the menus.

People's nutritional needs were assessed when they first moved to the home and then at least monthly. Where people were considered at risk, referrals to appropriate healthcare professionals had been made. There were care plans for each person to indicate their nutritional needs. People were regularly weighed and changes in weight were monitored and acted upon. Where people required additional monitoring of food and fluid intake this had been recorded. The staff had a good knowledge of the different textures of food consistency needed for people who had swallowing difficulties.

Information about the menus, including the ingredients which people might be allergic to, was available for people living at the home and their visitors to view.

We met a visiting dietitian who offered support to people who lived at the home. They told us that the staff followed their guidance. They said changes in weight or health were reported to them promptly and the staff made sure people's nutritional needs were monitored and met.

The manager had introduced a new audit which highlighted changes in people's weight and the action taken as a result of this.

People's healthcare needs had been assessed and recorded. Nursing staff were employed during the day and night to meet people's general health needs. The staff also worked closely with specialist external nurses, such as the tissue viability service and palliative care nurses. This meant that they could make sure they were providing the most appropriate treatment to people. We met a visiting tissue viability nurse. They told us the staff at Franklin House made alerts to their service whenever needed and asked for their advice and opinions. The tissue viability nurse provided care plans which the staff at the service followed. They told

us they felt the nurses at the service provided good care and treatment for wounds.

People were able to see their doctor and other healthcare professionals as needed. They told us they could request visits at the home and that the doctors made regular visits. Information about people's healthcare and changes in their needs was shared with visiting healthcare professionals. Care plans were updated with this information and there was evidence of regular consultations when people needed these.

The manager kept a list of everyone who lived at the home, their specific healthcare needs and how these were being met. For example information about swallowing difficulties, catheter use, people on warfarin or diabetic medicines and people with wounds were all highlighted on the information. This was updated each day. Therefore the manager was able to monitor how people at risk were being cared for. If people's needs changed or care was not provided as planned the manager was aware of this and able to take remedial action swiftly.

Requires Improvement

Is the service caring?

Our findings

Most people told us the care workers were kind and they had positive relationships with them. A few people said that some of the temporary staff were not as friendly. Some people felt the staff did not always attend to the ''little extras'', like making sure their flowers were topped up with water, or checking they were happy with everything. Some of the things people told us were, "I class this as my home and it gives me satisfaction to know (my relative) is okay. She would be fine in their hands'', ''they are very kind and I get good care here'', ''the staff are very good, nice and kind'', ''they are very very kind'', "there is a good rapport between everyone, staff and residents", ''the atmosphere on this floor is quite good'', "there is a good level of care, it is always clean and basic needs are looked after well", "I'm looked after well here", "I've been very happy here, I like it", "It's very good", "I couldn't say a bad thing about this place, they've been lovely", "It's very homely, if (my relative) has got to be anywhere, we're glad he's here'', "I would recommend it to others" and "She looks really happy, she is really happy here, Mum says 'It's very good here, they look after me'."

The relatives we spoke with told us they were kept informed by the staff. They said they thought the staff were caring. One relative told us, ''if anything happens they tell me straight away.'' Another relative said, "I know I can just go and ask staff, there is good communication."

We observed some interactions where the staff were focussed on a task rather than the person they were supporting. We witnessed one incident where a staff member spoke to someone in an unkind way, but apart from this all the staff were polite and kind when communicating with people. However, they did not always show consideration for people's personal preferences and feelings. For example, during lunchtime we saw three members of staff approach someone who was eating their main course and ask them if they would like their dessert. The person indicated that they were still eating their main course. The third member of staff brought them their dessert and left it next to them. The dessert was intended to be hot but was left without a cover next to the person for 20 minutes whilst they finished their meal. Whilst the person continued to eat a staff member removed their plate, then took their fork (which had food on it) out of the person's hand and gave them their dessert. None of the staff involved in this interaction responded to the person's wishes. In another incident the staff forgot to give one person their lunch until we alerted them to this. The majority of people in the dining room had been given their desserts or had finished by this time. The staff member who supported this person did not apologise for the lateness of the meal. They hardly spoke with the person they were supporting and they left the person without warning to attend to other tasks five times. When they returned to the person they did not explain why they had left or apologise for this behaviour.

People at lunch time were not given a choice of drink. The staff placed protective tabards on people and removed them without asking their permission and without offering a choice. When one person attempted to remove this the staff told them, ''don't take it off!'' Some of the staff used language which could be seen as offensive or patronising. For example, one member of staff asked a person if they had enjoyed their ''din dins.'' Another member of staff asked someone ''are you going to be a good girl?''

We also saw the staff move people's chairs and wheelchairs without explaining what they were doing or asking people's permission. In one case we saw a staff member moving someone's wheelchair backwards without any warning. The person had not seen the staff member approach and did not know they were about to move.

The staff did not always respond to people when they indicated distress because they were too busy attending to other tasks. For example, one person told three different members of staff that they felt hot, saying ''oh I feel hot'' and later, ''I feel really hot.'' They looked uncomfortable and were wiping their forehead with a napkin. Two of the staff did not respond or offer any support, the third brought the person a glass of water but they did not alert the nursing staff or acknowledge that the person could have been unwell or needing additional support. The staff were busy clearing tables and sorting out dishes in the kitchen. During the lunch on the first floor a staff member was vacuuming the corridor by the open dining room doorway and this was noisy.

In another dining room we heard people calling out for attention, for example when they wanted their desserts and the staff not responding to this. We also observed a staff member moving a person's hand without asking their permission or speaking with them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We discussed the incidents of concern which we witnessed with the manager and regional director. They told us they would be speaking with the staff concerned and reminding all staff about the importance of treating people with respect. They acknowledged that the practice described in the examples was not acceptable. The manager told us they would be monitoring the way people were supported at mealtimes.

However, the majority of interactions we saw were kind and positive. The staff offered people choices, bent down to speak with people and listened to their responses. There was a calm and relaxed atmosphere and the staff were generally attentive to people's needs. We observed a number of incidents where people were distressed or uncomfortable and the staff responded appropriately to these. One member of staff told us, ''it is a good place to work, the staff are all very caring.'' Another member of staff said, ''it is all about caring here and all the staff do that.''

The staff respected people's privacy, knocking on bedroom doors and asking permission to enter. They called people by their preferred names and offered people the opportunity to refuse care. When the staff used hoists and other equipment they explained what they were doing to people and they made sure people were comfortable, their clothing was adjusted to maintain privacy and they felt safe. People told us they were weighed in private and the staff discussed their needs in private. We observed that the staff were careful to make sure people's needs and personal information were discussed sensitively and in private.

People told us their cultural needs were met. Some people told us they had requested specific diets to meet their cultural needs. They also told us they were supported to attend places of worship or had opportunities to worship at the home.

Good

Is the service responsive?

Our findings

People told us their individual needs and preferences were met. They told us they could get up and go to bed when they wanted. They were able to have baths and showers when they needed and wanted these and they felt the staff respected their choices and wishes. Some people said they preferred to stay in their rooms and they felt supported to do this. However, some people felt they would like more opportunities to express their preferences. One person told us they did not have opportunities to speak with the manager or staff about their care or the service. Another visitor told us they would like the staff to make more effort to get their relative out of bed.

People's needs were assessed before they moved to the home. The staff created care plans based on these assessed needs. The care plans included information about their personal care, healthcare, social and emotional needs. The plans were clear and included details about people's preferences and how their individual needs should be met. They were regularly reviewed and updated. The staff had a good knowledge of people's individual needs. Care plans were computerised and printed copies were available for staff to view. The staff recorded the care they had provided each day. Some of these records focussed on the tasks the staff had performed rather than the person's wellbeing, but they showed that care plans were being followed. Where a specific need required monitoring, such as food and fluid intake, there were accurate records of this which helped the nursing staff to review and plan people's care. There were records to show that skin condition was being monitored and people who were bed bound were regularly repositioned to reduce the risk of pressure sores developing.

Records relating to wound care were clear and showed the treatment the staff had provided to people and the progress of the wound.

The staff we spoke with told us they had opportunities to read care plans and they knew people's individual needs.

The manager undertook regular audits of all care plans to make sure these were updated and reviewed as needed. Therefore if people's needs changed the manager made sure this was recorded so that all staff knew about the changes.

Some people told us they did not like to join in the organised activities or preferred to do their own thing. One person told us they did not always have the support they needed so felt they could not join in with events. However, other people told us they did like the organised activities. People felt there were enough things to do and others to socialise with. The staff had recorded details about people's individual hobbies, interests and information about their past lives, along with relatives, so that that anyone working with a person knew about these needs.

On the day of our inspection we saw that people were engaged in different activities including games, listening to music and an exercise group with a physiotherapist who visited each week. The manager told us

there were two main sessions for organised activities each day, including the weekends. During these times there were different events on each floor. There were also times of the day when no organised activities were taking place. Some of these times the staff were busy attending to other tasks and we saw people were left in communal areas with nothing to do and without much interaction.

The home employed an activity coordinator who planned and organised social events and activities. In addition all staff were expected to support people with their social activities and leisure time. Staff on each unit were assigned to offer support with a variety of group and individual activities. Some people chose, or needed, to stay in their bedrooms. The staff visited people to make sure they received support to pursue their interests. There were also special events advertised on notice boards around the home. These included a variety of events for Christmas.

There were books, games and other equipment available in different parts of the home for people to help themselves and for staff to support them with. Equipment was easily accessible and the manager told us people were encouraged to take what they needed. There were different things to do in each of the home's communal areas. There were different themes to the rooms so people could chose to use the music room, social club room and pub. The rooms could be booked by families to host parties if they wanted. There were various regular clubs and groups at the home, which people could chose to join. These included a group who ordered in a fish and chip supper from a take away once a week in the home's pub, a cooking group who used a specially adapted kitchen once a week to bake and a social group who had their own club room to meet each week.

There was an appropriate complaints procedure, and this was displayed around the home and available in the service user guide. People told us they knew what to do if they had a concern. They felt their complaints would be responded to appropriately. There was a record of complaints which had been received at the home and information about how the provider had investigated and responded to these. The Care Quality Commission received an anonymous complaint about the service. This information was shared with the manager. The manager responded with an investigation into the concerns and made a referral to the local authority in order to share the concerns and the action the provider had taken.

Good

Is the service well-led?

Our findings

Some of the things people told us were, "The home is well managed'', ''the staff seem to be happy, they talk to you with a smile on their faces and it cheers you up a bit" and ''the place seems well managed and runs smoothly.''

The manager had been in post since December 2014. He had previously worked as the deputy manager at Franklin House and another of Care UK's homes. He was supported by a deputy manager who was also the clinical lead for the home and unit leaders.

The manager and deputy manager had a good knowledge of the individual needs of each person living at the service. They were able to discuss individual care and specific needs. They had regular meetings with the staff to update themselves and they spent time on the floor at the service working alongside the other staff. The manager told us they had an ''open door'' policy and we saw staff and visitors speaking with the manager throughout the day.

The staff spoke positively about the culture at the home. They said they were well supported and the service was well-led. The staff liked the manager and said that he was available and approachable. One member of staff said, ''he is fair and it is easy to talk with him.''

During the inspection we discussed some areas where improvements were needed with the manager. These included observations of staff practice which did not show respect to the people they were caring for. The manager told us that action would be taken in response to these concerns. The manager told us about some of the changes that they had introduced at the service and improvements they had made. These included making applications for Deprivation of Liberty Safeguards and creating audits for different aspects of the service.

Care UK had asked people living at the home, their relatives and staff to complete surveys about their experience. They did this annually. The most recent survey results indicated that people were generally happy with the service. Where concerns about aspects of the service had been identified the provider had produced an action plan to address these.

There were regular meetings for people living at the home and their relatives. Records of these showed that there had been a discussion about the service and changes at the home. People were asked for their feedback about food, activities, the environment and staffing. Therefore people had opportunities to discuss their opinions about the service.

The provider had a number of different audits to help them monitor how the service was being managed. These included peer audits by other care home managers, audits by the provider's quality assurance team and checks by the regional director. We saw that the audits were well documented with clear outcomes for people and actions where improvements were needed. This meant the provider had a comprehensive view

of the service and whether any changes were needed.

The manager and staff undertook daily, weekly and monthly checks on different parts of the service. These included new checks introduced by the manager to monitor people's weight, wellbeing and safety. There were regular audits of medicines management and care planning. Therefore the manager had a good overview of how people's needs were being met and if any changes to care and treatment were needed.

All accidents and incidents were recorded including details of how the incident occurred and what action was taken afterwards. The manager audited these on a regular basis to make sure staff had responded appropriately and taken the necessary steps to keep people safe. The manager told us that where they identified concerns they addressed these in staff supervision and meetings. The manager also undertook an analysis of the accidents to identify any trends and look at how these could be prevented in the future.

The provider had created a service development plan which incorporated feedback from people using the service, staff and other stakeholders. It also included information from the provider's own audits. The manager and regional director regularly reviewed the plan and monitored improvements. The manager discussed these with staff and people living at the home so their views could be included in the plan. The manager told us the service improvement plan was regularly updated. Therefore changes which were planned and being made reflected the needs of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not always ensure service users were treated with respect. Regulation 10(1)