Care Quality Commission

Scarborough Hall Limited

Scarborough Hall and Lodge

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 13 February 2015 and was unannounced.

Scarborough Hall and Lodge care home is registered to provide residential care for up to 85 older people. There is a passenger lift to assist people to the upper floors and the home is set in pleasant grounds.

The home had a registered manager in place. 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.

People told us they felt safe at the home. Risks to people were managed well without placing undue restrictions upon them. Staff were trained in safeguarding and understood how to recognise and report any abuse. Staffing levels were appropriate which meant people were supported with their care and to pursue interests of

Summary of findings

their choice. People received the right medicines most often at the right time and medicines were handled safely. However, we noted one instance where a medicine had not been administered at the correct time. We have made a recommendation about this in the main report.

The home was not managed in a way to ensure that people were properly protected from the risks of cross infection. You can see what action we told the provider to take at the back of the full version of the report.

Staff were usually deployed in a way which ensured that people received the care they needed, however, sometimes we observed that care staff were engaged in activities which were not focused on people. We have made a recommendation about this in the main report.

People told us that staff understood their individual care needs. We found that people were supported by staff who were well trained. All staff received mandatory training in addition to specific training they may need. The home had effective links with specialists and professional advisors and we saw evidence that the home sought their advice and acted on this. However, we noted that there were occasional times when health professionals could have been contacted earlier to ensure people received the attention they required. We have made a recommendation about this in the main report.

People's nutritional needs were met. People were enabled to make choices about their meals and snacks and their preferences around food and drink were respected. However, we noted that staff were sometimes rushed at meal times and that they were engaged in tasks at this time such as washing dishes, which meant that people were not always assisted in a timely way or given the attention they required at this time. We have made a recommendation about this in the main report.

The home was clear about its responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), staff were suitably trained and supported people to make informed decisions about their care.

The home had developed effective links with healthcare professionals, and specialists were involved where necessary to ensure people had access to expert advice. However the arrangements in place to contact health care professionals could have been improved to ensure people always received medical assistance when they needed it. Staff with authority to contact such professionals were not always on duty and sometimes health professional advice was not fully implemented.

Staff had developed positive relationships with people and were kind and caring in their approach. We observed that they responded to people's care needs and attended to them politely and with kindness. However, people told us that some staff were not as kind as others and could sometimes be abrupt and rushed. We have made a recommendation about this. People were given choices in their daily routines and their privacy and dignity was respected. People were supported to be as independent as possible.

People were assisted to take part in activities and daily occupations which they found both meaningful and fulfilling. People told us that they enjoyed the activities which had been organised with individuals in mind. Staff had put thought into arranging an environment which would stimulate people's interests. For example we saw rummage boxes of interesting objects and interesting pictures on the walls which may stimulate reminiscence. Activities ranged from one to one time, group outings and clubs.

People were encouraged to complain or raise concerns. The home supported them to do this and concerns were resolved with learning points recorded to improve the quality of care.

The leadership promoted an open culture and people told us that the manager was approachable and responded to their comments. However, some people told us that the manager was not very visible around the home and that they would appreciate a more proactive approach. Communication at all levels was clear and staff understood their roles and responsibilities which helped the home to run smoothly. The provider understood the home's strengths, where improvements were needed and had plans in place to achieve these with timescales in place.

Systems were in place to assess and monitor the quality of the service. However, we have made a recommendation in the main report about ensuring that information gathered during auditing is used to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People told us that they sometimes felt safe but that they sometimes felt insecure because of the way people around them were acting due to their illness.

People were not protected because some areas of the home required attention to minimise the risks associated with the control of infection.

People had the opportunity to live their lives life without undue restriction because of the positive way risk was managed.

Medicines were managed safely.

There were sufficient staff who were safely recruited and trained in how to safeguard people.

Inadequate

Is the service effective?
The service was effective.

Staff were trained and supported to meet people's needs. The registered manager and provider supported them to develop professionally.

People had access to healthcare services however; one person told us that there had been a delay in their loved one receiving health professional attention recently.

The registered manager was fully aware of the principles of the Mental Capacity Act 2005 and how to make an application to request authorisation for a person's deprivation of liberty.

People were consulted about their meals, their nutritional needs were met and they had free access to food and drink. However staff sometimes appeared rushed and people did not always receive care focused on them at meal times.

Requires improvement

Is the service caring?
The service was caring.

People told us that staff were usually caring, however they were sometimes rushed. We observed that staff were kind and caring and that they understood people's needs well

Staff consulted with people and treated them with respect.

Good

Is the service responsive?
The service was responsive to people's needs.

Good

Summary of findings

People received personalised care which for most people had been discussed and planned with them or a person who acted on their behalf.

Staff worked to ensure people's lives were as fulfilling as possible. Care was tailored to meet the needs of people with a dementia and we observed stimulating activities which put each person at the heart of care. People's views were listened to and acted upon by staff.

Is the service well-led?

Requires improvement

The service was well led.

People told us the manager was supportive but that they would like them to be more visible around the home.

The culture was supportive of people who lived at the home and of staff. Lines of communication were clear. Staff understood their roles and responsibilities.

The registered manager had made statutory notifications to the Care Quality Commission where appropriate.

There was a quality assurance system in place which was usually effective. However, in the area of infection control it did not always lead to improvements in the service for people. Staff were supported to improve their practice across a range of areas.

Scarborough Hall and Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 13 February 2015 and was unannounced; it was carried out by one adult social care inspector, a hospital inspector and an expert by experience. The hospital inspector carried out a 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 with us. The hospital inspector also checked on the cleanliness of the home and infection control practices. The expert by experience spoke with people and made observations. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We did not request a Provider Information Return (PIR). The PIR 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. However, we gathered the information we needed during our inspection visit.

On the day of the inspection we spoke with ten people who lived at the home, seven visitors, and six staff including the registered manager and the housekeeper. After the inspection we spoke with two health and social care professionals about the service.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We looked at the recruitment, supervision and appraisal records of five members of staff, a full staff training matrix, rotas for the past two months, five care plans with associated documentation, a number of audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

The service was not safe. Standards of cleanliness in the Home were variable. When we walked around the premises accompanied by the registered manager we found that some areas of the home were clean and pleasant to be in. Some bedrooms and some small lounge areas were also clean. However, we saw that other areas of the premises were dirty and unhygienic. In the lounges we found debris and dust on a number of floors, chair cushions in the lounges were dirty on the undersides, some chairs for example in the second floor lounge were covered in a material which was difficult to keep clean and therefore presented a risk of cross infection. There was hard surface damage to furniture in the lounges and bedrooms which was also an infection control risk. Some en suite toilets and a number of communal bathrooms were dirty with uncovered paper towels, which were an infection control risk. A shower room contained many items unsuitably stored together causing an infection control risk. Three bedrooms were dirty; the en suite bathrooms in two of these were malodourous. The sealant for hand wash basins was damaged and in need of repair. A store room contained items on the floor but the shelving was empty. This was an infection control risk. The room was cluttered with bed linen, dirty 'crash' mats; dirty wheelchairs all stored together which was an infection control risk. We looked at two sluice rooms. In both there was an offensive odour. The manager explained that the sanitary bins in each sluice room were emptied three times daily and that the odour was managed through the use of an electric fan. The sink in a sluice room was not accessible as a bin was blocking easy use in both. We noted a member of staff who deposited clinical waste in the sluice rooms and then exited without washing their hands which was an infection control risk and not in line with the infection control training they had received.

We observed that there was a good system in place for keeping dirty and clean laundry separate and that laundry was colour coded to reduce the risk of infection. However, the floor of the laundry room was dirty and there were no cleaning schedules associated with the laundry room. This meant the home did not have an effective plan to keep the laundry room clean. The hairdressing salon had a dirty floor, the bin was full to overflowing and the hair drying machines had dusty hoods. We noted a member of staff dragging a dirty mattress without gloves or a cover for the mattress through the building and out towards a skip, this was an infection control risk.

We spoke with the housekeeper on duty that day. They appeared knowledgeable about infection control; however, they did not work to cleaning schedules and did not carry out regular cleaning audits to ensure areas which required attention were identified. From our discussion with the housekeeper and our observations of practice, it appeared that staff were not suitably deployed to ensure the environment was clean and hygienic.

We found that the registered person had not protected people against the risk of cross infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people told us they felt safe and two people told us they did not. For example, one person told us, "Yes, I think so" another person told us "I have no concerns. " One visitor told us that their relative was concerned about other people who lived at the home going into their room without permission which made them feel insecure. Another person told us that they went to bed one day to find another person in their bed. This had upset them as they wanted to feel they were secure in their room. One person told us, "I've had enough of this now. I want to go home. It's not the place, it's the people. Two men were fighting at the lunch table." One visitor raised concerns that a medicine patch had not been changed as prescribed and that this meant their loved one had not received their prescribed medicines at the correct time. We looked into this and have reported on it later in this section.

Staff had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they suspected or witnessed anything they considered abuse. Staff told us they had received safeguarding training and training records confirmed this.

The service had policies and procedures for safeguarding vulnerable adults which were available and accessible to all members of staff. Care workers told us they would refer any concerns to a senior member of staff and knew that they would also need to contact North Yorkshire County

Inadequate

Is the service safe?

Council which is the lead for the safeguarding of vulnerable adults in the area. This meant staff had the necessary knowledge and information to make sure people were protected from abuse.

We saw written evidence that the manager had notified the local authority and CQC of safeguarding incidents where necessary and had cooperated in investigations.

We looked at five care plans and saw individual risk assessments had been carried out for each person. The risk assessments we saw included behaviour which may challenge others and areas of personal care. Risk assessments included instructions for staff on how to minimise risk and guidelines on how to ensure people did not have their liberty unnecessarily restricted. Staff told us they understood how to protect people through following the risk assessments. They were clear, for example on how to approach people who may be distressed or agitated to calm them, protect them and those around them.

The home was purpose built for people who were living with a dementia related illness. The home was well lit, with wide corridors, suitable lifts and safe hand rails to assist people to move about the home freely. Areas of the home were accessible by code pad to ensure that people who would be unsafe to leave certain areas of the home were protected.

We examined staffing rotas and spoke with the registered manager about staffing levels. There were three senior care workers on duty each day, one for each floor of the home and thirteen care workers on duty across the three floors during the morning, with twelve during the afternoon. The registered manager, the deputy and team leader were supernumerary and cleaning and other ancillary staff were in addition to this. There were six waking staff on duty each night. This was to care for up to eighty five people. We saw on rotas that care workers were deployed with consideration of their experience and level of skill. New staff shadowed experienced staff, and there were extra staff on duty at the times of the day which required this such as between eight pm and midnight, to assist people into bed. When the manager was not available there was an on call system so that staff had back up when they required this. Through our observations and discussions we found there were enough suitably experienced and qualified staff to meet the care needs of the people living in the home. However, we noted that as lunch time was finishing staff were washing up large numbers of dishes in a kitchen area adjacent to the dining room at a time that they could have been interacting with people. This was an ineffective use of staff time and meant that people were not receiving the attention they should have been at this time.

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to beginning work at the home and that employment references had also been received. This provided evidence that only people considered to be suitable to work with vulnerable people had been employed.

The home had a policy on whistle blowing. Staff told us that they understood the whistle blowing procedure and were confident to raise any whistle blowing concerns.

We looked at the arrangements in place for the administration, storage, ordering and disposal of medicines and found these were safe. Medicines were stored securely in a trolley in a locked medication room. We checked the medicines for three people and found the number of medicines stored tallied with the number recorded on the Medication Administration Records (MAR). Medicines which were not in the Boots monitored dosage system and were kept in packets were dated on opening and a running total was recorded. This ensured that staff would know when medicines became out of date and needed to be re-ordered. Creams were for individual's use, were dated on opening and recorded on a separate administration record. There were suitable storage arrangements for controlled drugs. A register was kept as required, and this was signed and checked by two members of staff at the time controlled drugs were administered. However we noted that one person who received medicine in a patch from, had not received their medicines one day because they had been asleep and the member of staff had not returned to change the patch at a later time. This may have had a negative effect on the person's wellbeing, particularly as it was important with this type of medicine to administer it at the correct time. We checked the numbers of patches held in store against the MAR chart and these tallied, which suggested that other patches had been applied as prescribed.

Medicines which required refrigeration were stored in a designated fridge and staff recorded the temperature of

Inadequate

Is the service safe?

this daily. Staff training records showed that staff had received up to date medicines training. A list of all staff who had training and were authorised to administer medicines was available.

We recommend that the registered manager seeks best practice advice to ensure people always received their medicines, including controlled medicines at the time they are prescribed.

We recommend that the registered manager considers best practice advice to ensure staff are effectively deployed to meet people's personal and social care needs.

Requires improvement

Is the service effective?

Our findings

The service was effective.

People gave a mixed view of the effectiveness of care. Three people told us that staff were skilled in caring for them, three people raised some level of concern. When asked if the home contacted health care professionals promptly when needed a relative answered, “yes they do”. However, another person told us that they had taken their relative to the GP themselves because the member of staff they approached told them they needed to wait for another member of staff with the correct authority to come on duty before a GP visit could be arranged.

One relative told us that the more experienced staff placed food in front of (their loved one), told them the food was there and placed a knife and fork in their hands. The less experienced staff just put the food down and did not realise they needed to come back and prompt them. This meant the person did not always eat well at these times. A visitor told us that both they and their loved one were happy with food choices. One person told us, “The food is a bit better these days. But it's not very imaginative and there are too many sandwich suppers. Too much bread. I must say the Xmas day meal was superb. They're good on roasts but it's still a bit patchy.”

We looked at staff induction and training records. Induction followed required topics and there was an additional induction specific to the home, its values and philosophy of care. Staff told us that they had received induction before they began their mandatory training. During this time they developed an understanding of each individual’s care needs and the philosophy of the home. Staff understood about people’s clinical needs. For example, one member of staff told us that they regularly looked at people’s care plans, and that the registered manager encouraged them to refer any concerns to senior staff so that health care professionals could be contacted.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people’s individual needs and how risks were managed.

In addition to mandatory training, staff received specially sourced training in areas of care that were specific to the needs of people at the home. For example, most staff had received training in dementia care and specialist advice on palliative care. New staff without an NVQ level 2 in care commenced this training after induction.

Staff told us that they received regular supervision and appraisals and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and gave them support to give the care people needed.

The home had links with specialists, for example in diabetic care, nutrition, sight and hearing, pressure care, continence care and the speech and language therapy team (SALT). This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly.

The registered manager told us she had good links with local GPs and district nurses. We spoke with a health care professional after the inspection who had regular contact with the home. They told us that the staff were, “Generally very good, they contact us appropriately and most staff follow advice.”

The registered manager told us they used feedback from GPs and other professionals to help them give the best care they could and staff confirmed that they actively sought external professional’s advice. Records confirmed what they told us. For example we saw professional advice about nutrition had been incorporated into a care plan. We also saw advice from a community mental health nurse, and a tissue viability nurse which had been written into care plans to ensure people’s mental health needs, and needs associated with pressure care were met.

Care plans included information about people’s needs and preferences about their meals and drinks. We saw that those people who needed to be regularly weighed had these records in place, with actions recorded if changes in weight became significant. The ‘Malnutrition Universal Screening Tool’ (MUST) was used when necessary to ensure people were screened for risk of malnutrition. (The MUST tool was developed by the Malnutrition Advisory Group and is supported by a number of organisations).

Referrals to the dietician and speech and language therapist were recorded when people needed this with advice incorporated into care plans. For example, we saw advice about the use of thickened fluids in one care plan, and advice about ensuring a person who had sight

Is the service effective?

impairment received the nutrition they required,. However we learned through relative's comments this advice was not always followed. We also saw that nutrition and hydration charts were used and appropriately completed when necessary.

The registered manager told us that all food was produced on site. We noted that there was plenty of food offered throughout the day of our inspection, with drinks and snacks available at frequents intervals and whenever people requested. The service employed two chefs and two kitchen assistants and from our observations this was sufficient to ensure people received their meals when planned.

We observed a lunch time on different floors. The dining rooms were light, airy and laid out in restaurant style. The meals appeared appetising and good quality. We saw that people were offered a choice. For example one person chose a drink of fruit juice, others had squash and one person had a glass of wine. Coffee or tea was served at the end of the meal. Food was served from a heated trolley, was well presented and appeared hot. We saw that there were sufficient staff on duty to assist people with their meals. However, some staff appeared to be focussed on the task and not the experience of the people they were assisting. They assisted one person for a time and then left them midway through the meal and assisted someone else. This meant that people were left without support during the meal and their food became cold. This impacted on the overall quality of their meal time experience.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that a small number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place, but that nobody had yet been assessed as being deprived of their liberty. People's mental capacity was assessed to ensure that they had the support they needed to make decisions about their care. The registered manager explained two Best Interests meetings which had taken place recently , firstly to ensure a person was accommodated in the correct environment for their needs, and secondly to make a decision about covert administration of medicines. Independent Mental Capacity Advocates were used when people were assessed to have impaired mental capacity and required support with decision making.

When we looked at training records and saw staff had received up to date training on DoLS and the MCA. Care staff were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting power of attorney powers. The registered manager understood the implications of the recent Supreme Court ruling which had clarified the notion of deprivation of liberty for people in a care home setting. This meant that people could be protected regarding their mental capacity.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary, though sometimes there was a delay in their return.

Care records showed that people's consent to care and treatment was sought. Staff recorded how they looked for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. Discussions with people's chosen representatives were also recorded. This meant that the home ensured people were consulted about their care.

We recommend that the registered manager considers best practice advice to ensure that people are assisted with their meals in a way which focuses on them rather than the task.

We recommend that the registered manager considers best practice advice to ensure that advice from specialist health professionals is understood and implemented by all relevant staff.

Good

Is the service caring?

Our findings

The service was caring.

People told us that they were looked after in a kind and caring way. One visitor told us, “yes they always shut the door when delivering personal care.” One person told us that they felt listened to, and that some of the staff were kind but some were not. For example, one member of staff had told them in a short manner to “go back to bed.” The person’s relative added that although they had not witnessed staff being like this, their relative had been up during the night because they were concerned about an appointment the next day. The person also told us that sometimes it seemed that the task was important to the staff; however it may not be important to them.

Relatives and other visitors told us that they were encouraged to visit at any time and that they were always made to feel welcome.

The registered manager told us that staff concentrated upon giving people choices, so that they were as in control of their lives as possible. We saw that some staff did give people choices. Staff told us that they understood that it was important to support people to feel as independent as possible. They stressed the importance of giving people time to make choices and to take considered risks.

Staff spoke to people in a kind and respectful manner and clearly knew them as individuals. We observed staff knocking on resident's doors before entering. We also observed people expressing their wishes about what they were going to do during the day and what they wanted to eat and drink.

We observed that staff regularly consulted with people about what they preferred to do, whether they were comfortable or needed anything. We observed that people who were distressed or in discomfort were treated with kindness and assisted in a way which reduced their concern.

People responded to staff in a positive way and we saw many people smiling and looking relaxed.

A health care professional told us that staff were “kind to people and I notice they always knock on doors and respect people by providing privacy when they are giving care”.

The service had advocacy posters on display and the registered manager told us that people had used advocacy services in the past, though not so much recently. Most people had relatives or friends who acted on their behalf.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs.

People told us that they had interesting things to do with their time. One person told us, "I love the knitting club, and we have a good chat." However, another person told us, there was "not much for the blokes". A number of people who lived at the home and relatives mentioned the activities coordinator by name and made comments such as "She is superb. She is vital to this place."

We found that staff usually gave care in a way which put people at the heart of care. The people and visitors we spoke with each told us that they had worked with the senior staff to ensure the care plans met people's needs.

Care plans were agreed with people where possible or with those acting on their behalf. They contained details of how people preferred to receive their care, and most plans contained personal histories and information which would allow staff to offer care focused on each individual.

We saw that written plans were regularly reviewed by care staff to meet people's changing needs.

The home held monthly resident meetings to gain people's feedback and also often asked for the views of relatives and other visitors, which were recorded.

The registered manager and staff described an approach which was focused on the individual. The emphasis was upon meaningful engagement which enhanced quality of life and helped people feel worthwhile and fulfilled.

We noted that the corridors were decorated with attractive pictures, books and magazines were on shelves and personalised memory boxes outside people's rooms. For example, one person had a previous interest in football and the memory box contained images of them playing football and football memorabilia. Unfortunately one person who lived at the home had destroyed the contents of a number of these boxes. However, a member of staff who was employed to carry out activities with the people who lived at the home told us that they were thinking of ways to continue with the memory boxes without them being vulnerable to tampering. There were photographs of activities people had been engaged in throughout the home, which acted as a reminder of things people had enjoyed. In a number of lounges there was a copy of the latest daily magazine drawn up for people who were living with a dementia, called 'The Daily Sparkle' which contained interesting articles of historical, social and cultural interest. The home also produced a regular newsletter with letters and articles by people who lived at the home, relatives and staff. One news letter contained an interview with a person who lived at the home as they recalled memories of their younger days. Photographs were included of outings and works of art produced by people who lived at the home.

We saw rummage boxes of interesting items such as jewellery, scarves and hats and a number of people were enjoying the comfort of holding soft toys. One corner of a quiet lounge had been turned into an office space with a ribbon type writer, filing boxes and papers. Throughout the day of inspection we observed people handling objects of interest and we saw the activities coordinator and other staff talking with people about the objects.

The activities coordinator told us there was an extensive programme of activities every day, including outings, the regular and very popular knitting club, relatives and resident's meetings (monthly) and a birthday list, where people's birthdays were celebrated with a cake and special meal. The activities coordinator was a qualified art teacher and spoke enthusiastically about wanting to engage people in meaningful pastimes and to support residents to have fun and a sense of achievement. There was an annual competition for the home's Christmas card from the art group. Activities included music groups, walking and talking, museum visits, chairobics, craft club, visiting entertainers, buffet nights, a monthly church service, sherry evenings, music nights and reminiscence sessions. They also spoke about being aware of people's disabilities and support needs and working with them to maximise what they were able to do. The activities coordinator told us that people had the opportunity to make suggestions for activities at the monthly residents meetings, which the coordinator attended. They spoke about how they explored the potential benefits of each activity and then evaluated them with suggestions for improvement. People's feedback was used to help with future planning.

We saw an enclosed garden for people to sit out in, during nice weather. The activities coordinator also told us that some people became involved in planting seeds and tending flowers in the garden.

We spoke with people about whether there were interesting things to become involved in. Some people told us there were. Three people told us how much they

Good

Is the service responsive?

enjoyed the knitting club and two people talked with us about enjoying outings and music sessions. However, one person told us that the activities programme had not been explained to them and that their interests had not been consulted about or explored. They felt that the activities were very orientated towards females, with little for the men.

The staff and people we spoke with told us that the home encouraged visitors, and that the staff supported people to maintain their relationships. For example, they would assist people to make visits into the local community and invite relatives for meals at the home. People from the community were regularly invited into the home. During the day of our inspection we noticed that there were a number of visitors who were warmly welcomed by staff. We spoke with a health care professional who told us that they often heard about trips to interesting places in their regular visits to the home. They told us, "People get out and about, they visit the local garden centre and visit tea shops, and they also appear to get involved in a number of activities here."

People told us they were encouraged to express any concerns or complaints they might have and two people told us of times when they had discussed some area of concern to have it resolved. However two people told us that the registered manager was not proactive about talking with them and they often felt they needed to seek them out to raise concerns. We saw that the service had a complaint procedure and that people's concerns had been dealt with and recorded, along with any learning points for future care.

Requires improvement

Is the service well-led?

Our findings

The service was well led.

The people we spoke with confirmed that efforts were made to hear and act on their views. Lines of communication between people and management were open and supportive, though people told us that the manager was not always visible around the home and did not proactively seek out their views in conversation, which they would value. One person told us, “The manager is very pleasant but we don’t often see her.” However, the manager explained that they had been on a planned absence from the home for the past six months and were currently on a phased return to work. This may account for people not feeling they were visible around the home. The deputy manager had been covering the management of the home in the manager's absence.

Staff told us that the registered manager was approachable and supportive, that they listened to them and took their comments on board. Staff told us that the registered manager gathered their views both in meetings and informally, and that suggestions were appreciated and encouraged. The registered manager and staff all spoke about looking for ways to improve the quality of life for the people who lived at the home. For example, we spoke with the activities coordinator who worked hard to tailor activities and outings to suit the people’s preferences.

Staff understood the scope and limits of their role and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. The registered manager and staff usually reflected the culture, values and ethos of the home, which placed the people at the heart of care. However, there was some inconsistency in this, as some staff provided care which was task centred.

The provider told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. For example, the service was following the principles of the Social Care Commitment, which is a voluntary agreement about workforce quality. This had contributed to the personalised approach to care planning. The registered manager told us they were members of the local Independent Care Group (ICG). This showed a commitment to seeking information about best practice in care.

Communication with relatives and other interested parties was promoted through informal and formal meetings, questionnaire surveys and by a regular newsletter jointly produced by the staff and people who lived at the home. For example, areas such as activities, outings and menus were discussed. This had resulted in the introduction of taster days for new menu choices.

Notifications had been sent to the Care Quality Commission by the service as required.

The registered manager carried out audits on areas of quality and safety within the home and we sampled the results of a medication audit, an infection control audit, a care plans audit and other checks associated with a safe environment. We saw written plans where the need for improvements had been identified; for example, in writing care notes. However, we found that the auditing had not always been effective. For example, some infection control issues were not recognised through audit and were therefore not addressed. The registered manager told us that the results of audits were discussed in meetings and all staff were made aware so that any shortfalls were addressed to improve the overall quality of the service. Plans for improvements and progress towards achieving them were also openly shared with people who lived at the home in meetings.

We recommend that the registered manager consults best practice advice to ensure that the home operates an effective quality assurance system which results in improvements in the care people receive and the environment they live in.

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	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found that the registered person had not protected people against the risk of cross infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.