Bupa Care Homes (CFHCare) Limited

Carders Court Residential and Nursing Home

Inspection report

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Ratings

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

Overall summary

Carders Court is a care home providing nursing and personal care for older people. It is situated in the Castleton area of Rochdale. The home is purpose-built, single storey and comprises of five separate houses, each with 30 single bedrooms. There is plenty of car parking to the front of the home and there are garden areas around each unit for residents to sit out in.

We last inspected this service in January 2015. The service did not meet all the regulations we inspected and were given requirement actions for Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records and Regulation 23 HSCA 2008 (Regulated Activities) Regulations

2010 Supporting staff.

Summary of findings

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found one breach in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

We found parts of the home were not as clean as they should be, contained stained and defective equipment and unlocked cupboard doors caused a chemical or confidentiality hazard.

We have made a recommendation about the need to consistently gain consent to care and treatment for all of the people who used the service.

People who used the service said they felt safe at this care home. Staff had been trained in safeguarding topics and were aware of the need to report any suspected issues of abuse.

Recruitment procedures were robust and ensured new staff should be suitable to work with vulnerable adults.

We found the ordering, storage, administration and disposal of medication was safe.

Staff were trained in infection control and provided with the necessary equipment and hand washing facilities to help protect their health and welfare.

New staff received induction training to provide them with the skills to care for people. All staff were well trained and supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

The registered manager and other senior staff were aware of their responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

People were given a nutritious diet and had choices in the food they were offered.

Electrical and gas appliances were serviced regularly. Each person had an individual emergency evacuation plan and there was a business plan for any unforeseen emergencies.

We observed there was a good interaction between staff and people who used the service. We observed the good relationships staff had formed with people who used the service and how they responded well to any questions or advice people wanted.

Each person had an end of life plan and staff had been trained to care for people at this difficult time.

There were regular activities on offer and people were able to utilise the themed areas. We thought there could be a better program of activities for people with dementia.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and were regularly reviewed.

We saw people had access to a complaints procedure which gave people the information to raise any concerns.

Policies and procedures were available to staff for them to be able to follow good practice.

The registered manager and other senior staff held meetings with people who used the service and their families to gain their views. People were also asked to give their opinions about the service in an annual survey.

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?

Requires improvement

The service was not always safe.

Parts of the home were not clean, contained offensive odours and were not secured.

There were safeguarding policies and procedures to provide staff with sufficient information to protect people. The service also used the local authority safeguarding procedures to follow a local protocol. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. People were encouraged to take their own medicines with staff support. Staff had been trained in medicines administration and the manager audited the system and staff competence.

Staff had been recruited robustly and should be suitable to work with vulnerable adults.

Is the service effective?

Requires improvement

The service was not always effective.

Not all people who used the service had given their consent to care and treatment. Staff had been trained in the MCA and DOLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People were provided with a nutritious diet and sufficient fluids to maintain their hydration.

Staff were well trained and supported to provide effective care. Training and supervision were provided regularly.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were helpful and kind.

We saw visitors were welcomed into the home and could see their family members in private if they wished.

We observed there was a good interaction between staff and people who used the service.

Is the service responsive?

Good

The service was responsive.

Summary of findings

There was a suitable complaints procedure for people to voice their concerns. The manager responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

People who used the service were able to voice their opinions and tell staff what they wanted at meetings. Their families were included if they wished to attend and the manager responded to any issues raised.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Staff told us they felt supported and could approach managers when they wished.

Carders Court Residential and Nursing Home

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 was an unannounced inspection and was conducted by three inspectors, a specialist advisor and an Expert by Experience on the 08 of December and two inspectors on the 10 December 2015. 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 was experienced with people who were elderly and had dementia.

During the inspection we spoke with fourteen people who used the service, seven visitors/family members, eight care staff, the chef, the registered manager and area manager.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us.

We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This was because the provider would not have had sufficient time to complete the PIR.

During the inspection we carried out observations in the public areas of the home and undertook a Short Observation Framework for Inspection (SOFI) observation during the lunchtime period on the dementia unit. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for six people who used the service and medication administration records for eight people. We also looked at the recruitment, training and supervision records for three members of staff, minutes of meetings and a variety of other records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

Three people who used the service told us, “Everything’s spotless, the cleaners are brilliant”, “They keep my room clean and spotless” and “They keep everything clean and do my laundry every day. I’ve had no problems with them losing anything.”

There were policies and procedures for the prevention and control of infection. The training matrix showed us most staff had undertaken training in infection control topics. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health’s guidelines for the control of infection in care homes to follow safe practice.

The laundry was sited away from any food preparation area and contained sufficient equipment to keep people’s clothes clean. There was a facility for sluicing soiled clothes and different coloured bags were used to separate contaminated waste and laundry. Two people were employed specifically to do the laundry. Although one of the machines was broken we saw that arrangements had been made to have it fixed.

Staff had access to personal protective equipment such as gloves and aprons. There were hand washing facilities in strategic areas to prevent the spread of infection.

The cleaners had a laminated set of instructions they had to follow and signed a sheet when they had completed their tasks. This was monitored by management.

During the tour of the building we noted that three of the units were very clean and fresh smelling. However, two units (Brookfield and Linden) were not of the same standard. Three bedrooms we visited smelled of urine on Brookfield. There were also stained baths, the stools in two bathrooms were soiled underneath and some crash mats we observed were stained and damaged. The kitchen trolleys were also stained and had the remains of food on shelves and the door runners. When we toured the kitchen we saw that some tiles had food splashed upon them and other equipment was stained with what looked like food. The kitchen staff were still working at the time and on the second day of our inspection the trolleys had been cleaned as had the kitchen. On Linden we also found some rooms were not clean with dust and food on the floor, stained crash mats and baths.

All the communal areas we visited were clean. Furniture, fixtures and fittings were domestic in character and for the most part in good condition although some items such as seat cushions and crash mats were damaged.

On the second day of the inspection we revisited Brookfield and Linden and found they were clean and did not have a smell of urine.

On all the units we visited many doors marked as ‘fire doors keep closed’ were open. Some contained substances which may be hazardous to a person’s health, for example cleaning fluids and some contained confidential records which had been archived. The chemicals may prove harmful to people who may not recognise what they were. Confidential information such as personal records should be stored securely.

This was a breach of regulation 15 (1) (a), (c) and (e) and 15 (2). All premises and equipment used by the service provider must be clean, suitable for the purpose they are intended and properly maintained. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

People who used the service told us they felt safe at this care home. From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. Staff we spoke with confirmed they had been trained in safeguarding procedures and were aware of their responsibility to protect people. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service also had a copy of the local authorities safeguarding policies and procedures. This meant they had access to the local safeguarding team for advice and to report any incidents to.

The staff team had access to the 'Whistle Blowing' policy. This policy ensured that members of staff knew the procedure to follow and their legal rights if they reported any genuine issues of concern. The members of staff we asked told us they would report any concerns to the manager and were confident that appropriate action would be taken.

We looked at six plans of care during the inspection. We saw that there were risk assessments for nutrition, falls, moving and handling and tissue viability (this is for the

Is the service safe?

prevention and treatment of pressure sores). We also noted some people had risk assessments for equipment they used, for example bedside rails. We saw the risk assessments were reviewed monthly or sooner if required to protect people's health and welfare.

Three people who used the service told us, "There's plenty of staff, I know them all", "The staff are all regulars, when I press the bell, and they come quickly. If I called them at night, they'd come straight away" and "Some days they seem short staffed, but it doesn't affect me because I'm mobile.

Normally they're quick to come if I press the buzzer." A visitor told us, "They do seem short staffed because they're so busy. But they're not just task oriented, and they do spend time with our relative. There are some agency staff at times, but there's always a regular around as well."

We looked at the staffing levels and staffing records at the home. Each unit had a manager and dependent upon the numbers of people accommodated at the home between four and seven care staff. There was also a domestic assistant on each unit and a handyman available to carry out repairs. Care staff did not do any laundry and we saw three staff working in the kitchen. The registered manager said, "There are normally four care staff on each unit but we have brought extra staff in when the workload is high. We sometimes move staff from quieter units onto one that is busier. We are currently recruiting six new staff. Nurses are hard to find." Two staff members told us, "We have enough staff on our unit. This morning we were painting nails and singing carols. The only time we need more staff is when someone is ill" and "I think we need more staff sometimes especially when staff go off sick or on maternity leave."

We looked at five staff files. We saw that there had been a robust recruitment procedure for four of the five members of staff. Four files contained two written references, an application form, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision taken to employ the person or not. One staff member who came from abroad had only one reference from a previous employer and attempts to get two character references had failed. It would be good practice to ensure all staff have two references. This process meant staff were suitably checked and should be safe to work with vulnerable adults. Nurses had their qualifications checked with their governing body to ensure they were correctly registered and fit to practice.

There were mechanical aids in bathrooms and toilets. Hot water temperatures were checked and safe. Radiators did not pose a burns hazard and windows were all on the ground floor and therefore not a falling hazard.

We saw that the electrical installation, gas and electrical equipment was maintained, including the fire alarm system, water system to prevent Legionella and portable appliance testing.

Each person had a personal evacuation plan (PEEP's) to help evacuate them in an emergency. We noted that there was a business continuity plan which provided information for staff about the action they should take in the event of an emergency or the failure of a service, for example the gas or electricity supply.

Registered nurses or members of staff who had received appropriate training were responsible for the management of medicines at the home.

We saw that medicines including controlled drugs were stored securely on each unit of the home which reduced the risk of mishandling. The temperature of the storage areas were checked and recorded daily in order to ensure medicines were stored according to the manufacturer's instructions. There was a dedicated fridge on each unit to store drugs that needed to be kept cool and the temperature of the fridge was recorded to ensure it was working correctly. We saw that there was a safe system for ordering medicines which were checked when they were delivered to the home.

We looked at the medicines administration records of eight people. These records included details of the receipt and administration of medicines. We saw that there were no unaccounted gaps or omissions in the records. There were also records of unwanted medicines disposed of correctly by a licensed waste carrier. Staff we spoke with had been to visit the local pharmacy and shown how they worked to have a better understanding of the system. It was recorded on the medicines records if anyone had any allergies to medicines.

Some people were prescribed medicines to be taken when required, for example pain killers. We saw that guidance for

Requires improvement

Is the service safe?

staff to follow about when people might need to take their when required medicine was kept with the medicine administration records and gave staff clear information about when and for what the medicines were given for.

Managers audited the system and checked staff competencies to ensure the administration of medicines was safe.

There was a photograph on the medicines records to avoid any confusion over similar names and for staff to identify each person. People also signed their consent for staff to administer their medicines and we noted one person self-medicated.

We saw that staff had policies, procedures and other documents such as the British National Formulary and medicines information leaflets to support the safe administration of medicines.

There was some confusion over the terminology for the use of thickening agents for people who had swallowing difficulties. It told staff to use custard or syrup consistency which can be open to individual interpretation. We did see in the medicines records that staff were instructed upon how much thickener to use to get the desired consistency.

Requires improvement

Is the service effective?

Our findings

People who used the service told us, “The meals are very, very good, always good. A bit too good, I’m putting weight on”, “I’m happy here. They keep me fed and watered, everything you want, you are supplied with”, “The food’s good. I just get what they give me”, “It’s like a hotel here. The food is good, I get a choice and there’s plenty of it”, “There’s a choice of food, soup and sandwiches or a proper meal. It depends what’s on, what I have. It’s good”, “I like the meals and I get a choice. If there’s nothing I like I can order something else. Last time I had a poached egg on toast” and “The food can vary. Sometimes they exceed themselves, sometimes not. I don’t think they vary the choice enough. Last week we had chicken on 5 different days. It was cooked differently each time, but it’s still chicken.” Most of the people we spoke with were very satisfied with their meals.

On the tour of the building we visited all the dining rooms. We did note that some dining rooms did not contain seating for 30 people. The registered manager said they would have two sittings if the numbers of people wanting to dine at a table exceeded the number of seats. The tables were set with tablecloths, napkins and flowers. People could flavour their food with salt, pepper and sauces.

The meal served on the day of the inspection did not correspond with the menu. The scotch broth turned out to be lentil soup. There was a selection of sandwiches and we saw staff wore protective aprons and gloves although one staff member needed to be reminded to use tongues to serve the sandwiches.

We undertook a Short Observation Framework for Inspection (SOFI) observation during the lunchtime period on the Arkwright House. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Staff on this unit did not ask people what they wanted and just put the soup down before them but did ask what sandwiches they liked. Bread and butter was put on the tables for people if they wanted it with the soup. People did have time to eat their meals and were offered a choice of meal with the alternative hot meal of rustic bubble and squeak. There was a choice of sweet and people were offered drinks before and during the meal.

On Garfield unit people were asked what they wanted and given their choice of meal. We saw one person was given a meal which was not on the menu and had asked for it specifically. We were told by the chef that people did not contribute to the menus which were sent from BUPA head office. However, we saw from ‘residents’ meetings that food and menus were discussed with people who used the service. We were also told that sometimes there would not be enough of a particular meal and staff would ring around to see if any of the other units had some left over. However, all the people we spoke with said the food was good and nobody complained about not getting what they wanted.

The menus were displayed for people to see but a good pictorial guide was not being used on all units. This was a better menu for people with dementia or cognition issues.

We were told people could have their choice of breakfast from the usual breakfast cereals or a cooked meal. Drinks were served with meals and at other times spaced throughout the day so people could keep hydrated. We saw in the plans of care that people who had dietary problems would be referred to a dietician or speech and language therapist to have their needs met. Special diets such as for diabetics were provided and people’s weight was recorded regularly to ensure staff were aware of any weight loss or gain.

Meals were served by staff from trolleys and they checked the temperature of food prior to it being served to ensure it remained at a safe temperature. The member of staff serving the food said the chef manager went to a different unit each day to check staff were serving food correctly and to see if people liked the meal.

The kitchen had achieved the 5 star very good rating at their last environmental health inspection of January 2014, which meant the storage, preparation, cooking of food and cleaning systems were safe. We looked at the supplies of food and saw that there were good supplies and regular deliveries of fresh, frozen, dried and canned foods including fruit.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people

make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that staff had been trained in the MCA and DoLS. Staff we spoke with were aware of what mental capacity meant and how they were to let people make their own decisions if possible. We saw from the plans of care that best interest decisions had been made for any 'do not resuscitate' instructions but not always for care and treatment decisions. This may mean they have not consented to care and treatment. On one unit we saw that a best interest decision had been made using the correct professionals for her need to be on bed rest. Another best interest meeting had been made for a person to remain in the home for care and treatment. Four care plans showed evidence people had signed their agreement to their care and to be photographed. Two people on the dementia unit had not signed for their care and treatment or their agreement to be photographed.

We recommend that, to help ensure people's rights are protected, the provider consistently applies the principles of the Mental Capacity Act 2005 are considered so that valid consent is sought, acting in accordance with people's wishes.

Our records showed that over 70 DOLS decisions had been agreed and that the provider was sending the notifications in a timely manner.

New staff received an induction by being enrolled on the care certificate. This is considered best practice for new starters. Three staff members told us they had received an induction when they commenced work. Two staff members said, "I completed my induction and had an experienced member of staff support me until I was comfortable to work here" and "I had an induction and worked with a mentor for four days and then two days observation of my work. Each person on induction completed a workbook with a senior member of staff which showed the areas of expertise staff were picking up as they progressed.

Two visitors told us, "Most of the staff are well trained and competent, but there are always seniors around who know what to do and show them how" and "I think in a general sense, the staff are well trained , but perhaps need more specialised training about Alzheimer's and dementia."

We looked at the training records of the service and spoke to three staff about their training. We saw that the majority of staff had completed training in behaviour that challenges, food safety, fire safety, first aid, medicines awareness, infection control, MCA/DoLS, manual handling, nutrition, safeguarding, health and safety and the care of people with dementia. Nurses undertook further training in the safe use of syringe drivers, pressure ulcers and wound care and catheter care. Three staff we spoke with said they had completed all the training. One staff member said it was "training, training and more training at the moment".

Staff were encouraged to undertake further training in health and social care such as a diploma. Two staff told us they had completed level two and three and one staff member said she had asked to complete level three.

The registered manager and other senior staff were developing a supervision matrix and all staff were due an appraisal. This was not yet fully functional and although most staff had received formal supervision it was hard to tell from the records who had not. However, when the matrix is completed this will show when staff have had supervision and when it was next due. The three staff members we interviewed said they had received supervision and were given the chance to bring up their training needs or topics they wanted to.

People who used the service told us, "They know what I like and dislike and if they see that I'm under the weather, they call the doctor. They've given me the confidence to weight bear and teaching me to use the poles for transferring from the wheelchair to the toilet" and "If I'm poorly, they call the doctor, and they keep my daughter informed." We saw from looking at the plans of care that people had access to specialists and professionals to help meet their health needs including tissue viability nurses, hospital consultants, mental health specialists and district nurses.

Requires improvement

Is the service effective?

On the tour of the building we visited many bedrooms, which we saw had been personalised to people's tastes. Two people who used the service told us, "I like my room. I prefer being here than in the lounge, there are nice views. I think I'm lucky with this room" and I think I have a very nice room."

There was a themed area on each unit for people to meet and use including a pub. One person who was not on the unit with the pub told us he went with a family member to sit, chat and have a drink. On the other units there was a musical themed area, a tea room, an old fashioned shop and a music room. People from other units could visit the pub, tea room and sweet shop.

Baths and toilets had equipment to aid people with mobility problems to ensure they were bathed regularly.

Communal areas were clean and homely. People could sit in quieter areas or watch television together. We saw that people could also sit in their rooms if they preferred and use the gardens in good weather.

Signage on the dementia units helped people to find their way around and access their bedrooms and bathrooms.

Good

Is the service caring?

Our findings

People who used the service said, “They know me and know my habits, the time that I get up and when I like to go to bed”, “The staff are so friendly, so helpful. They have time to have a chat and a joke with me. They make me feel very comfortable in their presence.” “I like to have a cigarette after each meal, I have 3 a day. I look after my own cigarettes. They don’t take them off me”, “Kind? Of course they are. We like to have a laugh, they have a good sense of humour”, “I don’t mind the staff, up to a point. They’re kind and look after me well” and They’ve got a job to do. I can do a lot for myself. I can choose when I get up and when I go to bed.” A relative said, “I’ve no concerns about his care whatsoever, I’m here every day.”

We observed staff interacting with people who used the service during the two days of the inspection. Staff were polite and explained what they wanted the person to do before embarking on the task. We saw that for the most part people’s privacy and dignity were protected. We did see that a person was left with the bedroom door opened and it was explained that the person suffered from epilepsy and it was for her own benefit and safety. It would be good practice to record this in the plans of care. Throughout our inspection we saw that members of staff spoke to people in a courteous and friendly manner.

Each person completed a ‘My Day My Life document’. This gave staff a history of a person’s life, their family involvement, lifestyle choices and preferred routines. It also listed past hobbies and any religious or cultural needs. Visiting clergy held services and holy communion for people who wanted to practice their religion in this way.

We saw that current care records were stored in offices and cupboards which were locked and only available to staff who needed to access them.

We saw that people who used the service had their end of life wishes recorded in the plans of care. We also saw staff taking care of a person who was nearing the end of life and they were attentive to their needs. Pain medication was appropriately administered. The plans of care contained details of a person’s last wishes, including any religious or cultural beliefs, if they wanted to be cremated or buried and the name of the funeral directors they wished to use. Some members of staff had been trained in end of life care. A visitor told us, “A priest has come in to hold Mass and give her Communion. They’re aware that when the time comes and if there’s enough time we’d like a priest to come and give the last rites.”

We observed that visitors were welcomed into the home at any time. People who used the service could choose to receive their visitors in communal areas or in the privacy of their own room. We were told visitors could come at any time and use any of the facilities such as the bar or tea room.

Good

Is the service responsive?

Our findings

People who used the service told us, “If I needed to complain I’d mention it to my main carers and they’d sort it”, “They’re very kind and caring and treat me respectfully”, “I’m quite happy here, they help me dress in the morning. Sometimes I don’t like what they get for me and I tell them I want something else. They’ll say you know what you like don’t you and I’ll say Yes, I do”, “I’ve no concerns“ , “I’ve got no complaints, the staff listen to me. It’s alright here” and “I’ve never raised a formal complaint but I’ve mentioned to Lesley about the smoke room. Sometimes they leave the door open and it smells. But she says she can’t do anything about it because the room was in place before the law changed.”

Visitors said, “I’ve made a couple of complaints. Once when I had a word in someone’s ear it was sorted out straight away. The other time I’ve mentioned it to the House Manager and he’s suggested that I make a formal complaint, which I’ve just done” and “I’ve had discussions with the manager rather than make complaints and things have been sorted.”

A copy of the complaints procedure was made available for each person in the documentation they received when they were admitted to the home. The procedure told people how to complain, who to complain to and the times it would take for a response. It also gave the telephone numbers of other organisations people could complain to including the local authority, the Care Quality Commission and the complaints Ombudsman. There had been several complaints made against the service and we saw from looking at records that the manager had investigated the concerns and where necessary disciplined staff.

People who used the service told us, “There are plenty of activities, something every day, quizzes, bingo, singalongs. I like to do painting and those are my pictures all around my room”, “I can walk to the dining room, or if I fancy my meal in my room, I’ll just tell them. I like to read, in the Summer I’ll sit outside”, “There are a lot of activities going on, things we like to do. We’ve joined a choir and have a practise every Friday morning. We might not be much good, but everyone seems to enjoy it” and “He likes to sit in the quiet part of the lounge and just watch people. They try to encourage him to take part in the activities, but perhaps not very successfully.”

On the day of the inspection was saw that around ten people were involved in an art class, some people on one unit were singing Christmas carols and one person was completing a jigsaw. We saw people were able to read and watch their televisions in their own room or in the communal areas. There was an activities organiser who arranged for people to come from different units to join in activities. Other staff also arranged activities when the organiser was not there. However, we did not see many activities held on the units where people had dementia. We spoke to the registered manager about providing activities for people with dementia.

Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person’s abilities and preferences. Information was also obtained from other health and social care professionals such as the person’s social worker. Social services or the health authority also provided their own assessments to ensure the person was suitably placed. This process helped to ensure that people’s individual needs could be met at the home.

We looked at six plans of care during the inspection. Plans of care were individual to each person and contained sufficient information for staff to deliver good care. Plans of care told us what people’s needs where and what action staff needed to take to ensure people received a good outcome. The plans were divided into different headings for each identified need and reviewed at least monthly to keep staff aware of current care needs. Most of the plans we looked at had been developed and agreed with people who used the service which ensured their wishes had been taken into account. Two staff members said, “I ask people what they want and I am interested in them. I have sat and gone through the care plans. If you know the person you can tell they have deteriorated and pass this information on” and “I have read the care plans and pass on any relevant information to senior staff if I see any changes.

Staff did not always follow what was written in the care plans. Two plans gave details of people’s care, such as bathing but staff did not follow the instructions. This was because the person wished to be bathed more than staff were bathing them or not recording correctly what they had done.

Good

Is the service responsive?

Family members told us that staff kept them up to date with any changes to their family member.

Management held meetings with people who used the service and family members were also invited to attend. Topics discussed included the closing of the smoking room, the laundry, the key worker system, using the facilities such as the bar and the menu and food. Some of the comments recorded from people who used the service included, " Staff are brilliant and you can talk to them about anything", Night staff can be noisy first thing in the morning, can you ask them to be quieter", "Activities are great and available until 8pm" and "The laundry had improved and things not going missing as much." The laundry service had improved following a previous meeting. A visitor said, "My son has been to a few meetings and he's given them input." We saw from the meetings that the registered manager had responded to people's views. People had made Christmas cards, night staff had been asked to be quieter and people had used facilities on other units then where they were accommodated.

Good

Is the service well-led?

Our findings

The home had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service told us, "It's hard to beat this place, you wouldn't find a better home anywhere. The managers have got time for you. The registered manager is very approachable if you need to complain. If she was busy she'd soon get back to you", "I'd been here before for a short term when I was ill. Then It was decided that I needed care permanently and came back here", "I'm happy here, the place is run quite well. If anything crops up it gets sorted. The family get on well with the management" and "Sometimes, I have a bit of an off day, but I like it here. I'm happy and content."

Three relatives said, "We're aware of shortcomings in other care homes, we live locally. But we're satisfied customers", "They've made a good first impression. We were keen to bring her here. We're developing a good relationship with the management" and "It's fantastic. I've nothing but praise. He's settled in well, and they're good with us relatives as well." People and their families thought the home was well led.

Staff told us managers were supportive and available. This included the unit managers as well as the registered manager. Three staff members we spoke with thought there was a good staff team.

We looked at policies and procedures which included complaints, medicines management, mental capacity, falls prevention and management, infection prevention and control, hand hygiene, respiratory, outbreak management, communicable diseases and reporting, safeguarding, bereavement and advocacy, whistle blowing and health and safety. The policies were reviewed to provide staff with the relevant information they needed to help protect the health and welfare of people who used the service.

The maintenance man conducted regular audits to check systems, equipment and facilities at the service. This included the fabric of the building, the grounds, windows and doors. All equipment such as slings and hoists, the water system, including the cleaning of shower heads to prevent Legionnaire's disease, boilers, the laundry and fire alarm system were checked. This was recorded in the documentation was saw.

The registered manager and other senior staff completed audits for the accuracy and completion of care plans, pressure ulcers, nutrition, mortality, medicines management, GP reviews, the numbers of bedrails hospital admissions, safeguarding referrals, infections and infection control, complaints, concerns and compliments and resident involvement within the home. The registered manager told us of her plans to improve the audits that were used to audit cleaning. Currently domestic staff have to complete a document recording what they have completed but this was a very basic system that said the cleaning had been done. They worked off an information sheet which was kept on the cleaning trolleys and it would not be possible to check if the problems we highlighted had been completed daily when audited.

The service was also supported by a member of staff responsible for training and an area manager who also audited the quality of service provision.

We saw records for staff meetings which were held regularly. Topics included good care plan writing, supervision, appraisal, job roles and effectiveness, care issues and meal times. Staff we spoke with said they could bring up topics to help run the home.

The service had sent out quality assurance questionnaires in November and expected the results to be made known to people who used the service, families and staff in January. We did not see the results of the surveys at this inspection.

A lot of staff had worked at the home for some time which meant they knew the people who used the service well. Staff we spoke with said they knew the people they looked after well.

We saw that the manager liaised well with other organisations and professions. This included Social Services and external professionals involved in the Deprivation of Liberties Safeguards.

Staff told us they attended a staff handover meeting each day to be kept up to date. This provided them with information around any current changes to people's care or support needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **This was a breach of regulation 15 (1) (a), (c) and (e) and 15 (2). All premises and equipment used by the service provider must be clean, suitable for the purpose they are intended and properly maintained. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.** **All areas of the home must be clean, free from offensive odours and safe.**