Orchard House (Midlands) Limited

Orchard House Nursing Home

Inspection report

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West Midlands
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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 24 and 25 November 2014 and was unannounced. At the last inspection carried out on 2 September 2013 we found that the provider was meeting the requirements of the regulations inspected.

Orchard House is a care home which is registered to provide care to up to 31 people that require nursing care.

The home specialises in the care of older people who may have dementia and / or other health conditions. At the time of our inspection there were 31 people living at Orchard House.

Orchard House is required to have 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

Summary of findings

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. At the time of this inspection, there was a registered manager in post.

We found that the service had not consistently followed the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Referrals for mental capacity assessments or to restrict people's liberty had not always been applied for as they should have. We found that this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to individuals were assessed and special equipment was available to staff to use, however this was not always used in a safe way for people and meant that there was a risk of injury because staff did not always follow the training that they had been given.

We found that staff did not always have the information they needed about the people that lived there to respond to an emergency situation, such as a fire at the home.

All of the relatives spoken with told us that they believed their family member was safe living at Orchard House. Staff we spoke with told us that they thought people were safe.

People had their prescribed medicines available to them and appropriate records were kept when medicines were administered by trained care staff.

We observed incidences that were not person centred care. We saw some tasks were service led which showed the task was put before people.

The home had a safe system in place to recruit new staff and carried out necessary pre-employment checks. Staff received an induction and most staff received training and supervision.

We found that systems were in place to monitor the quality of service people received but these were not always robust.

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 consistently safe.

People who lived in the home were placed at risk because staff did not have the information about supporting individuals they needed to deal with some emergency situations that might arise.

There were not always enough staff to provide the support to people when they needed it.

Staff were recruited safely to work with people that lived there.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had not consistently followed the MCA and DoLS guidance. Referrals for mental capacity assessments or to restrict people's liberty had not always been applied for as they should have.

People were provided with food and drink to maintain their health but not always in sufficient quantities to meet people's individual needs.

Most people were supported to have access to healthcare professionals as needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not consistently show respect toward people or promote their dignity.

Most people told us that staff were caring toward them.

People were able to maintain contact with relatives when they wished to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not consistently have all of their individual needs met in a timely way.

People did not always experience personalised care.

People and their relatives felt that their concerns were listened to but not always acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to monitor the quality of the service provided but they were not always effective.

Summary of findings

People and relatives were asked for feedback but this was not in a robust way to include everyone and the format was not accessible to everyone.

Staff involvement in the running of the service was encouraged.

Orchard House 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 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.

The inspection was unannounced and took place on 24 and 25 November 2014 and carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to us as requested.

We also reviewed all of the information we held about the home. These included statutory notifications received from the provider. We asked the local authority and two healthcare professionals the opportunity to provide feedback to us about the home.

We spent time observing care in the communal areas of the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service. We spent time with 17 of the people that lived at Orchard House. We also spoke with five people's relatives, ten staff members, the registered manager and the provider.

We looked at six people's care records and other records that related to people's care to see if they were accurate and up to date. We also looked seven staff employment records, staff training records, and quality assurance feedback and audits, complaints and incident and accident records.

Requires Improvement

Is the service safe?

Our findings

People and their relatives that we spoke with told us that they felt safe at Orchard House. All of the staff spoken with described their responsibilities to us in relation to raising concerns about people's safety. They told us that they were confident about recognising and reporting abuse. One staff member told us, "I'd report any concern about abuse to the manager." This meant that staff understood their role in keeping people safe.

Staff told us that if they felt their concerns were not addressed they would 'whistle-blow' by escalating their concerns to external agencies such as Social Services or the Care Quality Commission. One staff member told us, "I'd look up the details of how to contact the right people." We saw that the provider's whistle-blowing policy did not give the contact details of external agencies that staff may require. We discussed this with the registered manager and provider and they told us additional information could be added to make the policy robust. This would ensure that staff had the information they needed available to them.

We saw that some risks to people were assessed such as moving and handling. One staff member told us, "[Person's name] does not have foot rests on their wheelchair due to the risk of injury to their skin." This showed that risks to people were assessed and appropriate action had been taken.

We observed one person was supported to stand by staff members using a moving and handling belt. We saw that the way staff used it was not safe and did not follow moving and handling best practices or the training they had completed. This showed us that although risks to individuals were assessed and equipment was available for staff to use, this was not always used in a safe way for people and meant that there was a risk of injury to them.

We spoke with staff about what they did in emergency situations, such as the fire alarm sounding. Staff spoken with told us that they had completed fire and first aid training. One staff member said, "I would check the fire panel and tell staff if they needed to move people from one zone of the home to another safe zone." Of the five staff we spoke with all of them told us that they had fire drill practices and that they assembled at the fire panel. However, none of the staff were able to tell us how they would safely move people, for example people nursed in their beds. One staff member told us, "I don't know." Another staff member told us, "I'm not sure what I'd use as we don't have any special equipment for people that would need full support to move." We asked if people had a personal emergency evacuation plan (PEEP) and were told that they did not. We found there was no equipment such as evacuation mats in place for staff to use in an emergency to safely move people that had, for example, mobility difficulties. We discussed this with the registered manager and provider and they told us that they were not aware of their responsibilities to give consideration to people's emergency evacuation plan and had not consulted with the fire service. This meant that staff did not have the information they needed to respond to such an emergency situation. Service providers are required to take responsibility for ensuring that all people can leave the building (or move to a safe zone) in the event of a fire.

The identified first aider on duty told us that they had recently completed their first aid training. However, we found that their training had not been effective as when we asked what they would do, for example, if a person choked or had a fall, they were unable to tell us the safe first aid response. However, other care staff we spoke with told us that they would summon help from the nurse on duty and the nurse was able to tell us the correct first aid action to take.

During our inspection we observed delays to people being provided with the care and support that they required. We saw one person asked for support to the bathroom and a staff member asked them, "Can you wait two minutes?" We saw that it was over twenty minutes later when they were supported as needed. Another person told us, "I don't think there are always enough staff on shift. When I need support to the bathroom I have to wait." Our observations and people's experience showed that staffing levels in the home were not always sufficient to meet people's needs when they required support.

We observed people and staff during one lunchtime. Staff told us that people who ate their meal in the dining room did not require staff support and we saw that this was accurate for most people that ate their meal in the dining room. However, we saw two people required support and one person's care records confirmed this to us. However,

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Is the service safe?

we saw that people who required support were at times left unattended and did not consistently have the support they needed. This was because at times there were no staff in the dining room.

Other people had their lunch in the television lounge or their bedrooms. We were told that lunch was served at 12.30. One person told us at 1.30pm, "I am still waiting for my lunch. No one has brought it for me." At 1.35pm another person told us, "I am really hungry. I've had nothing since breakfast and am still waiting for my lunch." We saw staff take them their lunch at 1.40pm. We saw that kitchen staff had prepared people's meals for 12.30 as planned but the shift lacked sufficient numbers of suitable staff to provide the care and support to people as needed during the mealtime.

We found that the provider had safe recruitment practices in place. One staff member told us, "I remember when I started I had an interview and the manager asked for references before I started." We looked at seven staff files and saw that pre-employment checks had been completed. This meant that appropriate steps were taken to ensure suitable workers were employed to work with people that lived at the home.

We saw that the home had suitable arrangements in place for the management of people's medicines. We observed one nurse administering people's medicines to them and saw that their medicines were available to them as prescribed by their doctor. We looked at three people's Medication Administration Records (MAR) and found all of the information required such as the amount of medicine received into the home and what had been administered. This showed us that people's medicines were managed safely by nursing staff members.

The registered manager told us that some people had medicine administered to them in a covert way that meant it was disguised, for example in their food. We looked at one person's covert medication administration protocol. We saw that this was in line with the requirements of the Mental Capacity Act 2005.

Requires Improvement

Is the service effective?

Our findings

We saw that some people that lived at the home may not have the mental capacity to make an informed choice about decisions in their lives. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a law about making decisions and what to do if people cannot make some decisions for themselves. DoLS are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Of the seven staff we asked about the MCA and DoLS one nurse and one care worker were able to tell us about the requirements. One staff member told us, “I recall watching a DVD about this." Although staff had undertaken training on the MCA and DoLS, some were unable to relate the training to protecting people's rights. This meant that most staff we spoke with were not able to demonstrate a basic awareness of the MCA or DoLS and how this may impact upon their job roles in protecting and promoting people’s human rights.

The registered manager told us that for the past four weeks they had decided that one person that lived there should be cared for in bed due to their risk of falls because an appropriate chair for their needs was not available to them. This was a restriction on the person’s freedom. We spent some time with them and saw that they may have lacked the mental capacity to make decisions such as agreeing to bed care. We saw that no referral had been made for either a mental capacity assessment or DoLS. We discussed this with the registered manager and they confirmed this to us and also that no referral had been made to an occupational therapist, for example, for the person to have an assessment for a suitable chair. This meant that the requirements of the MCA and DoLS had not been met. Staff did not always understand the requirements of the MCA or DoLS and did not always act in accordance with the law.

The provider told us that the registered manager had attended training on the MCA and DoLS and the registered manger confirmed this to us. They were able to tell us about their responsibilities under the MCA and DoLS and we saw that a referral for one person to have a DoLS had been made. They told us that they had spoken with the Local Authority for advice about further DoLS applications and that they planned to submit referrals for 14 people but confirmed to us that they had not yet done this. The registered manager told us, "The Local Authority told us not to send any further referrals for a while."

This meant that people could not be assured they would be provided with care only where they had provided valid consent or where this was in a person’s best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some of the people that we spoke with told us that they thought staff had the skills and knowledge for their job role. One person told us, “The staff are lovely and have the skills to care for me.” A few people told us that they thought staff needed to improve their skills. For example, one person told us, “I had a bad experience with one staff member using the hoist to move me. They hurt my arm. I don’t think they had the skills they needed for the job.” This meant that people had different experiences and opinions about whether staff had the skills they needed to be effective in their job role.

All of the relatives that we spoke with were complimentary overall about staff skills and knowledge in caring for their family member. One relative told us, “My family member is well looked after.”

We spoke with staff who told us that they had completed an induction and had completed a shift shadowing experienced staff when they started work at Orchard House. They also told us that they had completed some training during their employment. One staff member told us, “I think I completed most training when I started several years ago but there are other topics I think would be useful to me such as dementia training but haven’t been offered.” Staff told us that they had staff meetings. One staff member told us, “I feel listened to by the manager at staff meetings and that these are useful to the care team.” Most staff told us that they felt supported in their roles and had supervision. However, one staff member told us, “I’ve never had supervision. I think it would be good to have it.” This showed us that staff training and supervision were planned for but staff had inconsistent experiences, which could impact on their effectiveness in their job roles.

During our inspection we observed incidences of staff not demonstrating effective skills in their job role. We saw two incidences of staff using poor moving and handling skills when supporting people to transfer. For example, we

Is the service effective?

observed one agency staff member working with another staff member supporting one person to stand using a moving and handling belt. We saw that staff had not ensured the belt was well fitted and we observed it slid upwards under the person's shoulders. This showed us that training was not always effective.

Training records seen by us confirmed that most staff had completed some training that they needed for their job role. However, we saw that there were some gaps in staff training. For example, half of the nursing and care staff had not completed dementia care training. We discussed this with the registered manager and they agreed that there were some gaps in staff training and told us that they planned to provide further training.

People spoken with told us about different experiences with the food they received. People that ate in the dining room told us that their food was hot when served to them and commented to us that the food was, "Good" and "okay". However, two further people commented that the food was, "Dry and could have done with a sauce." We observed that one person asked for gravy and this was given to them but other people were not offered this. We observed that some of the dining room tables and trays being taken to people in the lounge or their bedrooms did not have condiments or gravy boats on them and staff did not offer these to people.

People in their bedrooms told us that hot meals were often cold when they arrived. One person told us, "The food is barely warm when it is brought to my bedroom. I've mentioned this to staff but it has not improved." We saw that food temperatures were checked at the point of serving onto warmed plates and that plate covers were available. However, we saw incidences of care workers taking uncovered plated food to people in their bedrooms. We asked one member of staff why they were not using the plate covers to keep the food warm and they told us, "I don't know." This meant that people did not always find their meal appetizing and staff did not always attempt to ensure food was served hot which showed staff did not have the knowledge they needed.

We saw that although drinks were given with people's meals and offered at set times during the day, people did not have drinks readily accessible to them. We did not see glasses of water or juice available for people to help themselves. We discussed this with the registered manager and provider and told them that we saw that people in their bedrooms and communal areas did not have drinks available to them. The provider told us, "People are meant to have drinks available to them." During our inspection some people asked us if they could have a drink. One person cared for in bed told us, "I have to wait for a drink. I've not even got a glass of water." Another person in a communal area of the home asked us, "Can I have a cup of tea, I am thirsty." When we informed a staff member of the person's request we saw that a cup of tea was given to the person but other people in the communal room were not offered one. This showed us that the set times for drinks were not enough to meet everyone's hydration needs.

We observed that one staff member took the afternoon tea trolley around the home to everyone in communal areas and bedrooms. We discussed with them our concern that some people would require support and the time it would take to offer everyone a drink. They agreed that it was not effective having one staff member doing the drinks. This meant that the arrangements for people to have drinks were not effective.

We saw that some people had fluid charts to record the amount that they drank. We discussed our concern about one person's chart with the registered manager and provider. We saw gaps of up to nine hours where no record of a drink being offered or taken by the person was recorded. The provider told us, "Staff probably forgot to fill in the chart." The lack of robust records meant that it was difficult to assess whether people's hydration needs were being met effectively.

We spoke with people about how they were supported to access healthcare services. One person told us that they were experiencing pain. Their family member told us, "I think the doctor is meant to be visiting [Person's name] today." During our inspection we saw that the doctor visited and provided a different treatment option that met the person's needs. One nurse staff member told us, "We can request visits from the doctor when needed." This showed that people had access to healthcare treatment when required.

One relative told us, "My family member had a health problem promptly identified by staff and early intervention treatment it from becoming a major medical problem. The staff always make sure the doctor visits [Person's name] when needed and we are kept informed. I feel my family

Requires Improvement

Is the service effective?

member has brilliant care from the nursing staff here." Records confirmed that people had access to health care professionals as required so that their health care needs were met.

Requires Improvement

Is the service caring?

Our findings

Most people that we spoke with told us they were happy with the care they received. One person told us, "The staff are polite and respectful" and, "Staff were generally good and I'm happy at the home, the staff are good to me." However, another person told us, "I like to talk to people, but staff don't really talk to me much. They help me with things I can't do for myself anymore but just do what's needed rather than talk with me." We observed that some staff spoke with people and engaged with them but other staff did not. For example, we saw one staff member place a meal in front of one person and not say anything to them before walking away. This meant that people's experiences of staff caring for them was inconsistent.

We spoke with two people's relatives that visited the home regularly and asked them if staff were caring toward their family member. One relative told us, "If I needed to go into a home I would be more than happy to come here, there is nothing bad at all and the staff are very caring". A further relative told us, "I'm overwhelmed with the love and care been given to [Person's name]."

Most of the staff we spoke with said people were well cared for at the home. However a few staff said they did not feel they worked in a person centred way and they believed things were task orientated. During our inspection we observed incidences of this. For example, we saw people were lined up in the corridor waiting for the toilet before lunch and tea time. One person told us, "You have to wait, it can be embarrassing". When we asked staff about this we were told that everyone wanted to go to the toilet at the same time and that this could lead to a queue. One relative pointed out the queue of people in the corridor waiting for the toilet to us and told us, "I don't feel it's right." We discussed this with the provider and they told us that they felt staff were being "time efficient" in having people queued. Our observations and discussions with people and relatives showed us that some tasks had set times which meant staff worked in a task orientated way that was not person centred or dignified for people.

We asked people whether they were involved in discussing and making decisions about their individual care needs. One person told us they were aware of their care plan but said that they had chosen not to contribute to it but knew that their family member had done so on their behalf. Another relative told us they were involved in discussing their relative's care needs with staff. They told us, "The manager made a hospital visit and completed an assessment involving my family member." The person told us that they were getting the care they needed in the way they wanted. This meant that people and their relatives had been involved in making decisions about their care and support.

All of the people we spoke with told us that overall they felt that their privacy and dignity was respected by staff. For example, people told us staff would knock on their bedroom door and wait to be asked in. We observed that staff generally interacted well with people and spoke with people in a respectful and caring manner. However, we observed staff supporting one person to go to their bedroom. We heard them tell the person, "We are going to take you to your bedroom," but saw that the staff then preceded with the task without talking with the person again but talking to each other and not involving the person or explaining to them what was happening throughout the task. This showed that a few staff did not always work in a way that showed respect toward people.

A few people that lived there showed us that they had their own mobile phone so that they could maintain contact with their relatives when they wished to. People's relatives told us that they were able to visit family members at Orchard House at any time and had never encountered any restriction on visiting. This showed that people were encouraged to maintain relationships with friends and relatives as they wished.

Requires Improvement

Is the service responsive?

Our findings

People that we spoke with told us about different experiences of their needs being responded to by staff. Overall, people told us that their physical needs were met but that they often they had to wait. One person told us, "Staff are always polite and respectful to me but it is not very nice when I have to wait, for example, to use the toilet."

We observed one person ask to be supported to the bathroom and heard staff ask them to wait "two minutes" but we saw that the staff member did not return to the person who became anxious. We observed the person's attempts to gain attention by calling out went unnoticed by staff and the provider in the room. We saw that it was 24 minutes after the person first asking to the time when the person's request was responded to which was not in a timely way.

We spoke with some people who chose to be cared for in their bedrooms. One person told us, "Staff meet my basic needs, but sometimes I feel so fed up. They don't really have time to talk with me much." Another person told us, "Staff do the job, but never really chat to me." This showed us that although people's physical needs were met other needs were not.

People told us that sometimes activities were offered in the home that they enjoyed. One relative told us, "My family member recently joined in a craft session to make poppies." The activities staff member told us, "Group activities are planned for and take place three times a week. We also have other sessions that we bring into the home. I also try to spend time and talk with people that stay in their bedrooms." On the first day of our inspection we saw that no activities took place but on the second day we saw that an armchair exercise session and a pottery decorating session took place. However, people we spoke to in their bedrooms told us no individual activities were offered to them over the two days of our inspection. One person told us, "I get bored and lonely." This meant that although activities were planned for and took place they did not always meet people's individual needs.

One person told us that they enjoyed knitting and we saw that they had this with them. Another person told us, "I love singing. I was in a choir. I get bored and fed up here." A further person told us, "I've lived here quite some time. We do some activities but not many. I used to like gardening but I've never been involved in the gardening here. I'd enjoy planting winter bulbs." We discussed this with the provider and they told us, "People have been involved in the garden during the summer and we do offer activities." This meant that some people were supported to maintain their own hobbies and interests whilst other people were not.

People's experience of their religious needs being met was different. One relative told us, "The home has enabled my family member's priest from their church to visit to give them Holy Communion." However, two people told us that they felt their religious needs were not met in a way that they wished. One person told us, "I would like to go to my Church where I used to go." We discussed this with the provider and asked if opportunities had been explored to meet this person's need. They told us that a local vicar visited the home which met the person's needs. This showed that people were supported to continue to practice their religious beliefs but this was not always in a way that individuals expressed to us that they wanted.

One member of staff told us, "I feel that things are task-orientated here." Throughout our inspection we observed incidences of tasks been completed by staff in a service-led approach rather than a personalised and responsive people-led approach. For example, we were told that men that lived at the home had an allocated 'men hair wash day' which the registered manager confirmed to us. We saw that medication was administered to people part-way through their meal which we saw was disruptive to their enjoyment of their meal. We discussed this with the provider and they told us, "It has been done like that for 25 years." This showed that a focus on tasks took place rather than on personalised care.

Care records sampled were personalised and detailed people's needs. However, one staff member told us, "We don't always have time to read people's care plans. Instead we just get to know the person over time as we care for them. " This meant that personalised information was available to staff but because they had not always read it they were not always aware of people's individual needs.

We asked people and their relatives what they would do if they had any concerns. One person told us, "I spoke with the manager and told them about my food being cold.

Requires Improvement

Is the service responsive?

They listened to me but nothing has changed." One relative told us, "I have raised some issues with the manager. They are approachable and I feel that they listen but there is not always a responsive action."

Another relative told us, "I mentioned to staff that I thought my family member's ears needed to be syringed and staff responded straight away." A further relative told us, "When [Person's name] moved to the home, I raised my concern about their weight. I feel that staff have really responded and supported [Person's name] to lose weight and become more healthy." This showed that people and relatives had inconsistent experiences when individual concerns were raised.

Requires Improvement

Is the service well-led?

Our findings

Most of the people, their relatives, staff and care professionals spoken with were complimentary about the manager and the quality of the service. Everyone said they knew who the manager was and they could speak with them whenever they wished. One person told us, "If I have any problems I can always go to [Staff name]". One relative told us, "There's always someone in the office. We are listened to and the matters are dealt with quickly and to our satisfaction". This demonstrated that the registered manager was accessible and approachable to people and their visitors and that people felt confident in approaching them. Although another person told us, "Staff do the job; it's just a job to most of them. Some staff are good but others just do the job." No additional information was requested from us by the provider.

The location of the manager's office was not easily accessible for people if they wished to see the registered manager. However, people we spoke to told us, "The manager is always walking around and talking to us." Although this was not our observation during our visit, staff commented to us that the manager took a "hands on" approach and would always help out. Staff also told us, "The manager has eyes everywhere."

On day two of our inspection one staff member told us, "Sometimes we have bad shifts like yesterday and we were struggling a bit. It was partly due to new staff and an agency staff member being on shift and they are not as familiar with people's needs." We were told that an experienced staff member rotered for the shift could not complete their shift due to unforeseen circumstances. We found that although another care staff member and activities staff member were at work on 'non-care shift' days and were completing paperwork we saw that the registered manager did not alter the rota plans to ensure suitable and sufficient staff were on shift to meet people's needs and keep them safe. We discussed this with the registered manager and provider and they told us that there were usually enough staff to meet people's needs and what we had observed was not a typical shift at the home. This showed that us that whilst the registered manager had recognised that the shift was difficult they had not moved staff from paperwork duties to help with care needs.

However, during the second day of our inspection we were made aware that on the previous day one staff member had to leave their shift early and other staff were new care workers. We observed that staff struggled to meet people's needs but did not see the 'hands on' approach by the registered manager that staff described to us. This indicated that staff felt the manager was visible and aware of what was going on within the service but we observed that this was not always the case.

People and relatives told us there were meetings to discuss activities and receive updates about the service. Minutes of the meetings showed us that people had the opportunity to feedback on any issues they wished to raise. We saw at one meeting more external activities had been requested such as 'wheelchair walks' and 'pub nights', although we could not see evidence to show these requests had been taken forward.

One relative told us, "The management have introduced a newsletter." The registered manager told that this was sent to relatives as a means of communicating with those who could not attend the meetings. We saw that the newsletter gave information on forthcoming events, information about the service and one relative spoken with told us, "I find that the newsletter is brilliant and helpful". This meant the registered manager was promoting effective communication about the running of the service.

We saw that feedback surveys were given to people but found that only six surveys were distributed to people at one time. This meant that that the other 25 people that lived at the home were not given the opportunity to give feedback. We saw that the most recent feedback survey completed by six people in July 2014 were in a written format that would not be easily understood by some people with dementia that lived there. We discussed this with the registered manger and they told us, "We send out six surveys to different people every three to four months. We've only used written surveys." This meant that the other 25 people that lived at the home were not given the opportunity to give feedback at the same time. Some people may not have been able to give their views due to the written format of the survey not been accessible to them. Opportunities therefore for people to give feedback were not as robust as they might have been.

Most staff spoken with told us that they had meetings where they were encouraged to put ideas forward to improve the service. We saw that the provider had

Requires Improvement

Is the service well-led?

implemented two improvements suggested by staff. For example, the introduction of a 'twilight' shift had been made during the summer 2014. This showed that the registered manager encouraged a culture where staff were involved in contributing to the running of the service and improving quality.

We saw that there were systems in place to monitor the quality of the service provided. These included audits of medication, infection control, care records and health and safety. We found that most of the systems of audit were robust. We saw one person's medication record had two gaps of missed signatures. The registered manager told us that they were aware of these and were investigating. This meant that systems were in place to address any error identified.

However, we found some audits were not always effective. For example, while the call bell audit checked that call bells were in working order, it did not include accessibility to call bells or timely responses in answering call bells. We observed that staff did not always ensure people had a call bell accessible to them to summon staff assistance if needed. We saw that staff were not always present in the communal areas and people did not have access to call bells. We saw that the call bell in the television lounge was out of reach to everyone in the room and that no call bell was available to people in the dining room. Of the nine people we spent time with in their bedrooms, we found four of them did not have access to their call bell. This showed us that additional checks were required to ensure effective monitoring of the service took place.

We saw that a concern had been raised to the registered manager in November 2014 by one staff member that people's food and drink charts were not been completed as needed. We discussed our findings relating to people's food and drink charts with the registered manager and asked if checks were completed to ensure that people's records were completed accurately. They told us that the charts were meant to be checked every day. We found incomplete and missing entries on charts which showed us that the checks were not effective.

The registered manager had been in post for 18 months which has provided stable management of the home. Most of the staff spoken with had worked at the home for a long period of time and had received 'loyal service awards' from the provider. This meant that people that lived there had continuity of care from the same staff members.

Staff told us and records confirmed that they had completed some of the training they needed. However, our observations showed us that this was not always effective, for example we saw poor moving and handling practices. One staff member told us that they had completed a refresher training course to update their skills from several years previously but they had found the content identical to their earlier training. They told us, "I did not learn anything new." Another staff member told us that they did not find the way that training was delivered met their learning style.

Before the inspection we asked the provider to send us Provider Information Return (PIR), this is a report that gives us information about the service. This was returned to us completed with an overview of the service and within the timescale requested. The PIR told us and the registered manager confirmed to us that they planned to ensure continuous training over the next twelve months that would address the gaps that we saw in people's training needs. Whilst this showed us that the provider was aware of some improvements being needed and that they had plans in place to address these we found no evidence to show that they evaluated the effectiveness of the training that staff had already completed.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not always have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided to them.**