St Philips Care Limited

Dearne Valley Care Centre

Inspection report

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Ratings

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

Overall summary

The inspection took place on 25 August 2015 and was unannounced which meant no one at the service knew we would be attending.

The service was last inspected in June 2014 and was found to be meeting the requirements of the regulations we inspected at that time.

Dearne Valley Care Centre accommodates up to 34 older people that require personal care. In March 2015 it ceased providing nursing care. Included within the home is a unit which can accommodate up to 12 people who may be living with dementia. At the time of our inspection there were 27 people using the service; 12 people on the unit for people living with dementia and 15 people in the rest of the home.

Although there was a manager at the home, they were not yet registered with the Care Quality Commission (CQC) but an application form was in progress to become registered. A registered manager is a person who has registered with the CQC to manage the service. Like

Summary of findings

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.

Staffing levels and resources were based on occupancy levels as opposed to people's individual needs. There were concerns that this could lead to a risk of people not receiving appropriate support. These concerns had been raised at a previous staff meeting.

Medicines were not always being managed in a safe way. We saw a number of times within the last month where the treatment rooms had exceeded safe temperature ranges to store some medicines. People said they got their medicines on time and we observed staff administer medicines in a safe manner. Medication administration records were completed but some topical cream charts had gaps in place.

We saw some care plans had not been reviewed for a several months but ones that had been were person centred. The manager had prioritised which care plans to review and all were in the process of being reviewed. Life histories were not included but this had been identified by the manager and a staff member was assigned responsibility for compiling these.

Staff knew how to report abuse and safeguarding referrals made appropriately. Policies and procedures were in place to guide staff as to how reduce risk of abuse. We saw evidence of decisions being made in people's best interests but consent was not always sought in accordance with the service's consent policy and the Mental Capacity Act (MCA) 2005. One person had a Deprivation of Liberty Safeguard (DoLS) authorisation and further assessments were to be considered.

We saw a number of activities take place which included making crafts and karaoke. We saw that people actively enjoyed these. We saw positive interactions between staff and people which included staff chatting with people. People we spoke with commented positively about the staff and how they were cared for. We saw instances of caring interactions between staff and people. We observed staff offer reassurance to people when they were providing support. People's privacy and dignity was respected and promoted by staff.

We saw evidence of regular 'residents and relatives' meetings and feedback surveys were provided annually to people and their relatives.

Regular team meetings took place with all staff. Staff comments about the new manager were very positive. Comments from professionals and feedback from people and relatives were also positive about changes in the home and the new management. We saw audits and quality monitoring of the service were completed routinely and actions were followed up appropriately. Analysis of incidents took place with an aim to reduce further recurrences. The manager made notifications to the commission where required.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

Improvements were required to make the service safe. Staffing levels were based on numbers of people and not their individual needs. This meant there was a risk that people may not be appropriately supported.

Some medicines were not being stored at safe temperatures. Appropriate documentation was not always in place to show necessary advice had been sought where required with regards to medicines.

Incidents of abuse were referred to appropriate authorities and staff were aware of the need to report abuse. Risk assessments were in place to guide staff how to manage and reduce risks for individuals.

Is the service effective?

Requires improvement

Improvements were required in the effectiveness of the service. Staff did not currently have regular supervisions and appraisals. Training was provided for staff however some staff did not find the learning method useful.

We saw evidence of decisions in people's best interests but consent was not always sought in accordance with the service's consent policy and the Mental Capacity Act 2005. One person had a Deprivation of Liberty Safeguard authorisation and further assessments were to be considered.

People spoke positively about the food and we saw people had access to, and input by, a number of health professionals where required.

Is the service caring?

Good

The service was caring. People gave positive comments about staff, the care they received and how they were cared for.

We saw positive interactions and communication from staff towards people when providing support. Staff and people had developed positive friendly relationships. People felt, and observations showed, that privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive. Care records reflected people's needs and were reviewed, or in the process of undergoing review.

We saw a number of activities take place which people enjoyed. We saw staff spent social time with people where they were able to.

Resident and relatives meetings took place which meant people had opportunities to feedback about the service and suggest improvements. There was a complaints procedure in place and most people said they would feel comfortable in raising any issues.

Summary of findings

Is the service well-led? The service was well led. The manager was not yet registered with the commission but an application was in progress. Feedback from people, staff and external professionals was very positive about the new manager. Quality assurance surveys captured people's views with an aim to improve the service. An internal audit system was in place which identified areas improvement. The manager and audits had effectively identified some shortfalls in the service. Team meetings took place regularly. Incidents and accidents were collated and analysed and the manager made referrals to other organisations where necessary.	**Good**

Care Quality Commission

Dearne Valley Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 25 August 2015 and was unannounced.

The inspection team consisted of one adult social care inspector and a specialist advisor with experience of older people's care and mental health.

Before our inspection, we reviewed information we held about the service which included statutory notifications of deaths and incidents. We contacted commissioners of the service, the local authority safeguarding team and the local Healthwatch, for any relevant information they held.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted several health and social care professionals who had involvement with Dearne Valley Care Centre and received feedback from a GP.

During the inspection we spoke with eight people, and four relatives and friends of people, who lived at the home. We undertook informal observations and spent time with people in communal areas to observe the care and support being provided.

We spoke with the head of care, the manager, a senior care worker, five care workers, the cook, ancillary staff and the administrator.

We viewed a range of records about people's care and how the home was managed. These included the care and medication records for five people, recruitment records for two staff members, policies and procedures, audits and meeting minutes.

Requires improvement

Is the service safe?

Our findings

We asked people at the home whether they felt safe. People said they did. One person said, “I’m quite safe enough here. I don’t hold back what I think.” We asked people and relatives whether there were enough staff. Comments included, “The residents should not be left in the lounge unattended” and “The girls are run ragged.” A professional told us, “There could be more staff but I can always find someone.”

The majority of staff we spoke with told us they felt staffing levels were not suitable. One said that, “People are not doing without but staff are rushed and it’s not fair on people.” The main view was that staffing levels, and hours, automatically reduced when numbers of people at the home reduced. Staff felt staffing should be based on needs of people and not just the number of people. This affected all areas of the home including care, kitchen, housekeeping and activities. As the home was not currently at full capacity staff felt they were being rushed or compromised in areas with the current resources. One comment was that management of existing staffing resources could be better.

Staff were present in communal areas the majority of time we observed on the ground floor. On the unit for people living with dementia where people had greatest dependency needs, we noted four occasions during lunch that people in the dining and lounge area were left unattended, the longest period being five minutes. We had concerns that the lack of appropriate supervision at meal times could put people with high level needs at increased risk of harm. One staff member commented that they would like time to sit with a person to support them to eat their meal but they were not able to due to other tasks which included supporting other people at the same time.

Two staff members were based on the unit for people living with dementia. Ten people required the assistance of two staff for some of their needs, particularly for hoists and mobilising. Seven people on the unit were being cared for in bed at the time of our inspection for various health reasons. The manager and head of care told us they did not currently use a dependency tool to assess the needs of people to help inform staffing levels. The latest care staff meeting minutes we saw from 24 August 2015 documented staffs’ concerns with staffing levels in place. This included what they told us, and what was acknowledged by the manager, that the dependency needs of the people should be taken into account.

We found there was a risk of people receiving appropriate care due to sufficient staff not being deployed to safely provide the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff we spoke with knew about different types of abuse and the process to follow to report any concerns. Staff told us they undertook annual safeguarding training and we saw this documented on the training matrix. We saw policies in place for safeguarding and whistleblowing, which is where a worker reports bad or unsafe practice within the home. Information was displayed publicly within the home detailing where concerns should be reported to. Safeguarding concerns were appropriately reported by the service to the local authority where required. This showed that there were processes in place for staff to follow to minimise the risk of abuse occurring.

People’s care records contained risk assessments that covered a variety of areas which included nutrition, continence, skin integrity and other identified areas of risk. These had been reviewed on a regular basis and we saw evidence of updates in response to any changes in needs to ensure risks were managed appropriately.

We asked people about their medication. One person said, “They [staff] bring me my tablets in a morning and watch me take them. They’ve never forgotten them.” Another said, “Staff give me medication. I always get it ok.” We observed a staff member administer some people’s morning medication. They followed safe practice, were patient and stayed with the person until they had taken all their medication. Medication administration records (MAR) were completed only once the medicine had been taken. The staff member was able to tell us about, and we saw in place, the processes for ordering, storing and disposing of medication safely.

Controlled drugs are medicines which must be stored and administered under strict guidelines and legislation, due to their harmful effects if not managed correctly. We saw the service’s controlled drugs register was correctly filled in with amounts and two signatures as required. The amount of drugs stored corresponded with amounts documented.

Requires improvement

Is the service safe?

MAR sheets we looked were also filled in correctly and using correct codes where required. We checked two people's medicine that was administered PRN (as required). These were recorded appropriately on the MAR sheets and it was documented in each person's care records that PRN medication had been given. We saw each person had PRN guidance in place which had information about when, why and how a person may take any 'as required' medicines. This meant staff would have clear guidelines to follow to help ensure people received their medicines safely and appropriately. The manager had recently introduced topical cream charts to show staff where people required creams to be applied and to keep a record of applications. However, a sample of six charts we looked at contained gaps so it was not possible to confirm from these charts people had their creams. The manager said this could be due to staff not being fully familiar with the documentation which would be highlighted at the next meeting.

One person in the home was receiving their medication covertly. There was a covert medication plan in the file with the MAR sheets but this had been in place since 2013 and needed reviewing as the person's medication had changed. There was a more recent care plan in place but the information in this differed from the one in the medication records. There was no documentation in place to show the person's capacity had been assessed and to evidence this method was in the best interests of the person. There was no documentation from a pharmacist to advise how the medicines should be given safely, for example in certain drinks or food. We discussed this with the manager who told us she would ensure necessary information was in place.

We looked at the treatment room on each floor where medicines were kept. We saw that medicines were not always being stored within a safe temperature range. On the ground floor we saw 15 occasions in August 2015 where the temperature had exceeded the safe storage upper limit of 25 °C, sometimes reaching 28 °C. We checked the labels on bottles of medication which stated they should be stored under 25°C. On the first floor treatment room we also saw occasions where the room temperature had exceeded safe range. We saw that nutritional supplements were stored in an old medicine trolley in the treatment room. These should have been stored in a cool dry place. The manager told us, and we saw in the morning, that the medicine trolley would be kept in the corridor whilst still secured to the treatment room to try to counter the high temperatures. However, this meant the treatment room would then be unsecured and it was also not a practical long term solution. If medicines are not stored at correct temperatures this can impact upon their effectiveness.

We found medicines were not always being managed in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We looked at the recruitment files of two recently employed members of staff and saw that these contained application forms, details of previous employment history and references which included previous employment and character references. We saw Disclosure and Barring Service (DBS) checks in place. DBS checks help employers to make safer recruitment decisions. The information we saw showed that processes were in place to ensure people were checked and assessed as suitable to work at the service.

A maintenance person was employed at the service who had responsibility for regular checks to maintain the safety of the premises and equipment. Along with another staff member we spoke with, they were also a fire marshal with responsibility for showing new staff necessary safety information. We saw information in place which stated what support each person would need to evacuate in the event of an emergency. In the kitchen/dining area of the unit for people with dementia we saw an electric kettle, cutlery, tea, coffee, cereal and other good were on display and accessible to people. There were currently no people on this floor who would be able to independently access these but the manager assured us she would address this issue to minimise the potential risks this entailed. The home had a comprehensive health and safety policy in place which set out the requirements and procedures staff needed to follow to ensure the service operated safely.

Requires improvement

Is the service effective?

Our findings

People and relatives felt they, or their family member, were looked after by staff who supported them with their needs. One relative commented, "The staff are great here, he is really well looked after." A visitor told us, "I can approach any of the staff and they will tell me how [my friend] has been." A health professional who visited on the day told us, "Staff know about people's needs. They adhere to everything we advise and follow treatment plans." A GP provided feedback that, "Staff are aware of the patient's problems."

We saw that people's health needs were managed effectively. We looked at the records of three people who required position changes on a regular basis to minimise the risk of them developing pressure areas. We checked the people's records and saw there were repositioning charts in place to show that these people were repositioned on a regular basis. Special mattresses and cushions were in place where people required these.

Discussions with staff showed they were knowledgeable about people's health needs and could tell us about specific people's conditions. Staff told us they were kept updated about changes to people's needs and said they got a good handover so information could be passed on between shifts. This helped to ensure people were supported appropriately and received effective care as required.

Staff told us they received training for their roles with a majority of this training provided online as E-Learning. Most staff we spoke with did not find this approach very useful or beneficial. Comments included, "Prefer more hands on training than E-Learning" and "Do not think it is as effective as a classroom setting." The manager told us that she was looking to incorporate a mixture of training to be delivered to staff in future and in further areas. During our inspection we spoke with a training assessor who had been sought by the manager to set up staff for further vocational training. The assessor told us, "[Manager] is very proactive with staff and very keen on training." We saw the training matrix which showed the majority of staff had completed the training required. Where training was due or not completed, this was highlighted so that action could be taken to ensure required training was completed.

Staff told us they received an induction when they commenced in their role which included completion of practical workbooks and working alongside experienced staff for a period of time. Supervisions are meetings designed to support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. Most responses from staff were that they did not receive regular supervisions and appraisals. They did not know the frequency these were expected to take place and some referred to having only "a couple" and "a few" in long periods of time. They attributed this to the several previous management changes at the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The manager was aware of this shortfall and had identified it as an action to reintroduce these regularly. One staff member confirmed this and said, "In our last meeting [Manager] says supervisions are coming up."

The head of care told us about future plans for implementation of an accredited care certificate and that a member of staff had been identified to become a mentor to coach and assess new staff. The staff member was booked onto an upcoming management course to equip them with relevant skills. This showed that there were opportunities for staff to progress within their roles.

People's views of the food were positive. They told us, "I'd give the food six stars (out of five) if I could, it's that good", "It's lovely the food, always get enough of it", "I'm never hungry, never been hungry since I've been in here", "Get a good breakfast, I like to have something different" and "You get good food." Another person said, "I like a cooked breakfast and can have one every day, the food here is very good." We saw jugs of water and juice available for people in communal areas and in people's rooms. We observed staff offering people both hot and cold drinks throughout the day. One person told us, "I get special cutlery" which assisted them to be able to eat independently.

We observed people eat their lunch in the dining room which was bright and spacious with tables neatly set. Napkins and condiments were available on each table and music played low in the background. People mainly sat in small groups and talked amongst each other. The food looked appetising and people ate at their own pace. Staff

Is the service effective?

did not rush people and were present to ask if people wanted more food or wanted assistance. People were offered choices of meals and drinks. We also observed lunchtime on the unit for people living with dementia. Two people were sat in the dining room, and two were sat out of choice in the lounge. The remaining people ate, or were supported to eat, in their rooms as they were cared for predominantly in bed. Staff were aware of who was on a soft diet and cut up food for people who had difficulty in doing so. Staff appeared more rushed on this unit than the ground floor as most people needed extra support to eat.

People were assessed for their risk of malnutrition and care plans were in place to reflect people's nutritional needs. People's weights were regularly monitored and reviewed so that any significant weight loss or gain could be identified and acted upon accordingly. We saw food charts in place for people who had been identified as requiring these. However, we noted a number of entries about what people had eaten stated descriptors such as 'toast' 'cake' 'mash' and 'sandwiches' with no amount documented which meant an accurate picture of what someone had eaten could not be captured. The manager told us she would ensure such information was recorded in future.

We spoke with the cook who was knowledgeable about people's nutritional needs and told us they were able to accommodate people's dietary requirements, for example if someone was a vegetarian or required a specific diet. There was a choice of meals available and they told us they were able to accommodate people's preferences if they did not want what was on the menu.

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

One person at the home had a DoLS in place and we saw they had necessary documentation in place. The manager told us that they had allocated some time with a regional manager to evaluate all of the people in the home, where they may lack capacity, to establish whether further authorisations were needed.

MCA and DoLS training was provided to staff who demonstrated a varying knowledge of the legislation. We observed staff ask for people's consent before providing care. Care plans showed decisions were made in people's best interests and with involvement of people and their families. However, improvements were required to ensure this was applied correctly, consistently and in line with legislation. For example, one person had a consent form in place for bedrails. This had been discussed with, and signed by, a family member on their behalf but the only capacity assessment in place was from over a year earlier with regards to making 'complex decisions'. There was no decision specific assessment for the use of the bed rails which meant it could not be evidenced appropriate steps had been taken to attempt to gain the person's consent in accordance with the MCA 2005. This was also not in accordance with the service's own consent policy, which stipulated 'bed rails' as area where consent needed to be obtained. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw people were referred to other health services as required. A staff member said the home had a good relationship with the local district nurses and they could ring them anytime for advice or a visit to a person. Care records evidenced involvement from a number of varying professionals including doctors, memory team professionals, specialist and district nurses. This showed that people were supported with their health needs in a holistic way. The chiropodist was there during our visit and several people used this service. One person told us, "I'm going to get my feet done. They always feel lovely afterwards."

Good

Is the service caring?

Our findings

We asked people their views of the service and the staff who supported them. Comments included, "I don't want to be in a home but if I have to be, I'd rather be here. It's perfect. All staff are nice, and the cooks. If you want 'owt doing they do it. There's no argument", "You can't grumble about the staff", "It's alright, I'm comfortable here" and "Couldn't find a better place to be looked after, much better than hospital." We spoke with one person who had difficulties in communicating verbally. We asked them "Do you like it here?" and "Do you like the staff?" The person nodded 'yes' in response to each question. The manager had recently received a card from the family of a person who had stayed at the home which said they had, "Nothing but praise for the staff."

Relatives told us, "They look after my [family member] who can be awkward at times, I have no complaints to make about the home, they are a good lot of girls" ,"The staff always talk and offer me a drink" and "I come every day to see my [family member]. It's ok here, staff are nice."

Two professionals visiting the home told us "I think the staff are great" and "Staff are friendly whenever I've been. They seem happy." A local GP stated in feedback to us, "Staff are caring."

We observed positive interactions between staff and people. We saw that people were offered choice at all times, for example of what they wanted to eat and drink, what they wanted to watch on TV and what they wanted to do. We saw one interaction where a staff member was sat with a person helping them to choose what colour nail polish they wanted to wear. The person said to the staff member, "You're a goody" and the staff member responded, "I like to help." We found there were positive, friendly relationships between staff and people. One person told us about a cosmetic cream they liked to use which they had recommended to a staff member during chats. They told us, "They [the staff member] liked it so much they went and bought some for themselves." We saw visitors also joined in with laughing and joking with the staff and there was familiarity and friendliness apparent from our observations throughout the day. When staff were in communal areas we saw them interact with each person present and make sure that everyone was ok and ask if anyone needed anything.

At one time we saw a person become impatient and they raised their voice to staff. Staff remained calm, patient and respectful with the person at all times. When staff assisted people, reassurance was given and staff explained to the person what was happening. People were encouraged to be independent and where they required assistance they were supported at their own pace and were not rushed. We saw staff sit down and speak with people who were sat down so they were on the same level. One person sat in a lounge was unable to hear well and we observed staff sitting at the side of them, talking closely so they could hear, understand and contribute. We saw the person laughing at times. At one point they asked for a biscuit and staff were aware of what they liked and went to get this for the person.

Staff gave examples of how they treated people with dignity and respect. One staff member told us, "I treat everyone how I would like my mum and dad treating." Whenever we saw care workers going into people's rooms they always knocked and called out "hello", even if they got no verbal response from the person. One person confirmed this was common practice and said, "They [staff] tell me before they're coming in" and also gave another example of their privacy being respected. They said, "They take me to the office if they have anything private to say or tell me." A local GP said about staff in feedback that, "They always take the patient into a room to be examined." Staff received training in equality and diversity and we saw throughout our inspection that people were treated with respect, regardless of their differences. We did see on the unit for people living with dementia that records containing personal information about people were kept openly in a dining area that was accessible to people and visitors. The records were not always in the vicinity of a staff member. A staff member told us they had asked for a locked cupboard so this problem could be addressed.

Care records, although personalised within individual care plans did not contain information about people's life histories. The manager told us that this had been identified as lacking and the activities co-ordinator was in the process of compiling and implementing life histories and social plans for people in the home. We also saw this action documented on the latest home audit which corresponded with what the manager told us. Information about people outside of their care needs is valuable to provide

Good

Is the service caring?

knowledge for staff in order to understand a person and know how best to support them. This is especially important for staff that may be unfamiliar with the people, such as new staff.

Good

Is the service responsive?

Our findings

Three of the care records we looked at had not been reviewed since April 2015. The manager was aware of this and was working to complete reviews of all care plans. We saw evidence of this in a document where the manager had recorded dates of all care plans and was prioritising the care plans that needed rewriting and reviewing. The remainder we looked at had been reviewed within the last month and had new care plans written that were person centred. The manager told us about, and showed us, where senior staff members were each assigned a number of people's care plans for whom they would have responsibility for reviewing and updating. We also saw new front sheets for care plans that had been produced which were to go in people's files which included a photograph and captured key information about the person. This showed that actions were in progress to improve and update all of the care records.

We saw instances of staff responding to people's needs during our inspection. A care worker checked whether a person, cared for in bed, felt like their breakfast. They accommodated the person's specific request and drink which was quickly prepared and taken to the person. Staff overheard one person saying they needed the toilet and immediately went to their assistance. Another person had received a postcard from their family member and staff read this out to them as they struggled to read it independently.

Another person told us they liked to get up a certain time each morning as this was a time they used to rise to start their employment some years ago. The person said it was their choice to rise at this time and they went to bed whenever they felt like it. One person told us they liked to read a particular newspaper each day and said staff had arranged for this to be delivered to the home daily. A staff member told us it was important that they responded to people's specific wishes such as respecting if someone wanted to have a lie in, or someone wanted to have time on their own. Staff showed familiarity with people's preferences and provided care and support in accordance with these.

We spoke with the activities co-ordinator who worked five days a week at the home. They told us they planned a weekly schedule of activities but these could be changed in response to what people wanted to do each day. They told us some recent activities included a 'pub party', trip to the seaside and an outing to a local garden and farm. Another party was planned that week at the home. They acknowledged it was sometimes difficult to include everyone in activities as some people chose not to take part and some people were cared for in bed and not able to attend. They told us they would spend one to one time with people to try to balance this. This included chatting with and reading to people and reminiscing. They told us they were discussing new ideas with the manager about further initiatives and activities, one of these was an upcoming 'Royal Week' where the people were going to have a themed party and write to the Queen.

We asked people about activities at the home. One person we saw engaged in making crafts told us, "You've got to have activities haven't you. I like doing crafts. I don't want to just sit there, it's important." Another told us about a recent party at the home, saying, "I enjoyed it, let my hair down." They had also been on a recent trip out of the home and told us, "It was a lovely day." They went on to say they sometimes had a walk round the garden with staff and told us another person who had lived at the home had been supported to attend church. The activities co-ordinator told us they often held a quiz at the home. We saw one person thinking up questions to use at the next quiz which they told to the activities co-ordinator to use at upcoming quizzes.

We saw various activities take place on the ground floor. We saw a group of people partaking in craftwork at a dining table. We saw the activities worker actively encouraged people to participate. One person who was unable to see was encouraged to sit at the table and listen. The person said, "Ooh yes, I'd like that." We saw karaoke take place with several people in the lounge and people were encouraged to sing along and dance. People were laughing and enjoying themselves. Some people, who chose to, had their nails painted and chose what colours they wanted to have on. Where people watched TV and listened to music we saw staff ask people their preferences first. We also saw that people's choice to have time on their own was respected. One person was sat alone in a lounge with a cup of tea. We asked if they were going to join in any activities and they told us, "I like to sit on my own with a cup of tea and have my quiet time now and again."

One the unit for people living with dementia we did not see any structured activities take place. The TV was on for

Good

Is the service responsive?

people to watch and we did observe staff interacting with people. We heard a care worker chatting with someone in their bedroom however there were limited opportunities for staff to spend meaningful social time with people. One relative told us, “I am concerned my [family member] on this floor has no-one to talk to and carers haven’t time to sit and talk to them.” The manager and head of care told us about future plans to improve activities throughout the home.

There was a complaints procedure on display in reception which provided details of how to make a complaint and other organisations people could contact with concerns. We looked at the latest documented complaints, the last of which had been made in December 2014. We saw that the complaints had been investigated proportionately with the findings documented and outcomes and learning fed back to the complainant.

People told us they would feel comfortable to raise any concerns with staff and/or the manager. One person said, “I’d complain if I needed to. I’m a gobby one.” Relatives told us they would feel comfortable approaching staff for any issues. One said, “No complaints at all.” The manager told us that she tried to speak to relatives and people whenever she saw them and would ask if they had any complaints. This showed a pro-active approach to try to manage and resolve any issues quickly.

‘Residents’ meetings took place which the activities co-ordinator chaired. Relatives could attend and we saw minutes of the last that had taken place in July 2015. This contained themes for discussion which included activities and food. One person at the home told us, “We have regular meetings. We had one recently and the new manageress, [name], came. She’s very good. I like to ask for more activities.” Another said, “We have meetings, I remember us all getting together. Everything’s alright.” This showed that there were opportunities for people to give their views with an aim to influence how the service operated.

Good

Is the service well-led?

Our findings

Since our last inspection, three managers had been in place at the home. At the time of this inspection, the current manager had only commenced employment several weeks earlier. The manager was not yet registered with the CQC but had submitted an application in order to become registered which was in progress at the time of our inspection. The manager told us they felt supported by their regional and senior management in their new role. They told us the immediate priorities at the service were improving staff morale, medication and care plans. They told us there was work to do to get the home to their own standards but had plans as to how they wanted to achieve this. From discussions, the manager was knowledgeable about people in the home and their needs. A staff member said they had been pleased to hear from the manager that was one of her main aims. The manager told us, "How can I deliver a good service if I don't know my own residents. I need to be able to answer a relative when they ask how their family member is."

We asked staff their views of the manager and how the service ran. Staff told us about feelings of uncertainty with past changes of manager but all spoke positively about the current manager. Comments included, "She is great, staff morale was rock bottom, she has lifted us. She has worked her way up and knows how hard it can be, she will get a pinny on and help us", "Whole atmosphere at the home is better and the residents are more settled", "She worked a night shift here recently, really hands on", "She has a good team behind her", "She has assured us she is here for the long haul, and we are willing to support her to make this home great". Another told us that it was positive that the manager "watches how things are done before making suggestions where we can improve" as opposed to implementing changes 'for the sake of it'. Another comment was that "She's realistic and will sort any issues out. Very professional." Two staff said they felt morale was "a lot better" and "getting there" but wasn't quite 100% yet.

All staff said they felt supported and comfortable in addressing any issues with the manager. Throughout our inspection we saw the manager and head of care were present around the home and interacted positively with people, staff and visitors. There was a relaxed friendly atmosphere which supported staff comments that they "like being at work now."

One relative told us that over the time their family member had been at the home they had met several managers but, "This new manager has time to talk to me and even if she is busy she makes time." Visiting professionals on the day stated, "The new manager is turning it around here" and "She's bothered about the residents. Doing the job for the right reasons." Feedback from a GP stated that they believed the running of the home was satisfactory and highlighted that there had been a high turnover of managers in the last couple of years. They went on to state, "The standard of care is good for residents."

We saw that since the new manager had commenced employment, staff meetings had taken place with each staff group which included, care staff, kitchen staff, domestic staff and seniors. The meetings included discussions around training, staff concerns, new systems and new documentation. Staff were acknowledged and recognised for their contributions in their role.

We saw there were monthly provider visits completed by the regional manager with evidence of actions completed and an action plan to take forward for each visit. We saw the manager had a number of audits in place and looked at a sample of these. These included audits relating to medication, nutrition, infection control and care plan audits. Where shortfalls had been identified, we saw actions to address these. The manager had already identified areas for improvements and had implemented a number of new systems, for example charts to show what support people had with personal hygiene and new cleaning schedules. This meant there were systems in place to assess the level of service, identify any areas that needed to be improved and put actions in place.

Where we had identified breaches of regulations and areas for improvement during our inspection, most of these had already been identified by the manager. Where they had not been, the manager, where they were able to, pro-actively addressed the issues.

Accidents and incidents were logged each month and reviewed for any trends or themes. The manager had introduced a document she intended to use at service level where she could log and pick up any similarities or repeat incidents. These were also logged on the service's electronic quality assurance system so that head office had oversight of the same.

Good

Is the service well-led?

We saw the findings of the last annual quality assurance surveys from December 2014 on display in reception for people to see. The majority of responses were positive. The head of care told us these were sent to people using the service, relatives, staff and external stakeholders. Where satisfaction fell below a certain level, an action plan was generated. This meant there were processes in place to capture a holistic view of the how the service ran.

The manager submitted notifications in accordance with the statutory notifications required to be made in line with the Health and Social Care Act 2008. She was aware of the circumstance of when these should be submitted.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment was not always provided in accordance with relevant legislation where people lacked capacity to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Medicines were not managed in a proper and safe way to make sure care and treatment was provided safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed in order to meet the requirements of the service. Staff did not receive appropriate supervision and appraisal as was necessary to enable and support them to carry out their duties.