Care Quality Commission

# Chantry Retirement Homes Limited

# Euroclydon 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? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Good |

## Overall summary

This inspection took place on 25 and 26 February 2015 and was unannounced.

At the last inspection on 25 June 2014 we asked the provider to take action to make improvements to how the home was kept clean and in how it was maintained. The registered provider told us they would meet these legal requirements by 1 November 2014. We found these actions had been met.

The service predominantly cared for older people and could accommodate up to 49 people. At the time of the inspection 39 in total were cared for. A separate unit provided support to people who lived with dementia.

There was 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 person's have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Arrangements for the management of medicines were generally good but some people had not had their medicines administered correctly and this had resulted in them not taking their medicines as prescribed. This was a breach of the Health and Social Care Act 2008 (Regulated

# Summary of findings

Activities) Regulations 2010. The evidence was gathered prior to 1 April 2015 when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force. You can see what action we told the provider to take at the back of the full version of the report.

People were safe because the environment was cleaner and better maintained. People were protected from abuse because staff knew how to recognise this and report any allegations of abuse. Staff knew how to raise their own concerns, if they had any, and were aware of how to contact relevant external agencies if they needed to. People's human rights were upheld and people were not discriminated against. Robust staff recruitment practices ensured people were protected from those who may not be suitable to look after them. Accidents and incidents were responded to quickly and monitored.

People's needs were met and their risks managed. This was despite, at times, the staffing numbers falling below what the management staff ideally wanted to provide. This subsequently had meant that some people had not received their support at a time that they would have preferred to have received it. People received the care and support they needed from staff who had the skills and knowledge to provide this. Staff received training and support and were actively encouraged to improve their practice and knowledge.

People's consent was sought before they received care and treatment and people who were assessed as lacking mental capacity, were protected under the appropriate legislation. People received support to eat and drink and any related risks were managed.

The people staff supported mattered to them and they provided their care with compassion and understanding. People's dignity and privacy was maintained. People were recognised as individuals and the people who mattered to them were included and communicated with where possible. People who lived with dementia were looked after by staff who had a real passion for this area of care and who delivered very person centred care. People's care was planned with them or their representatives if more appropriate. People's views and preferences were sought and included in the planning of their care. People had opportunities to take part in a large selection of activities, if they wished to. Activities were designed to be meaningful to the person taking part. People generally told us their concerns and complaints were listened to and responded to, although because of the way these were recorded, it was not possible for us to ascertain if this was always the case.

The service had a strong leader who ensured all staff knew what her expectations were and that these were met. Staff worked well together and were predominantly driven to ensure people were cared for well. Staff and people were actively encouraged to be involved in contributing to decisions made about the service. Monitoring arrangements ensured the services were provided safely and consistently.

# 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. People had not always received their medicines safely and correctly.

People's needs were met and their risks were managed. People were protected from abuse.

People now lived in a cleaner and safer environment.

**Is the service effective?**

Good

The service was effective. People's health related needs were met. They had access to external health care professionals. They were supported to attend health related appointments.

People's consent was sought prior to them receiving care or treatment. People who lacked mental capacity to give consent or make decisions for themselves were protected under the appropriate legislation.

People were cared for by staff who had received training and support to further their understanding and knowledge. Where staff had not received specific training, other staff had and were able to advise and take a lead.

People's nutritional risks were monitored and managed.

**Is the service caring?**

Good

The service was caring. People were treated with kindness and compassion and their dignity and privacy was maintained.

People's distress was acknowledged and addressed.

People's independence was promoted and staff helped people to retain the skills they had.

People mattered to the staff and the staff supported people to maintain relationships with those that mattered to them.

**Is the service responsive?**

Requires Improvement

The service was not always able to be fully responsive. The call bell system did not make it easy sometimes for staff to effectively respond to people's calls for help.

People had access to information which told them how to make a complaint.

Where possible people or their representatives were involved in their care planning and were

# Summary of findings

**Is the service well-led?**

Good

The service was well-led. An open and inclusive culture supported people and staff to be involved in decisions made about the service.

People's views were sought with a view of using these to improve services provided.

People were protected against unsafe care and treatment because there were effective quality monitoring systems in place. Necessary improvements were made to the service in order to improve outcomes for people.

# Euroclydon 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.

The inspection took place on 25 and 26 February 2015 and was unannounced. The inspection was carried out by two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. In this case the expert by experience was knowledgeable in the care of people with dementia.

Before the inspection we reviewed the information we held about the service which included information from the provider about significant events. We asked local adult social care commissioners for a copy of their latest contract monitoring report. We gathered information from health care professionals who visit the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We spoke with eight people who use the service and four relatives. We spoke with 12 members of staff as well as the registered manager. We reviewed eight people's care files and reviewed various care records for a further 12 people. These records included assessments for the use of equipment, mental capacity assessments, records of people's weight, repositioning records and food and fluid intake charts. We looked at six staff recruitment files as well as other records relating to staff training and the support they received. We looked at the service's maintenance records and other records relating to the management of the service. For example, quality monitoring audits, action plans, minutes of various meetings, incident and accident reports and records relating to complaints.

Both the service's current registration certificate and employer's liability insurance certificate were on display.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe. One person said "safe, good Lord yes". A relative said the staff were "patient, aware and attentive". When talking about the communal rooms this relative said "they keep an eye on everything. They intervene and don't let things overbalance, it's timely intervention."

However people did not always receive their medicines appropriately and safely. Staff who administered medicines had their competencies in this task checked. However, we found three different tablets under three different armchair cushions in the main lounge. These medicines appeared to have been in people's mouths at some point. We were unable to establish if there had been a negative impact on the person or people who had not successfully swallowed their prescribed medicines. However, it did demonstrate that the arrangements for ensuring people received their medicines correctly and safely were not robust enough.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. (This corresponds to a breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

All medicines were securely stored and monitoring checks were carried out to ensure the correct stock was present. A record of all stock returned to the pharmacy was maintained. There were no unexplained gaps on people's individual medicine administration records (MARs). Staff were signing that medicines had been administered and taken. Particular guidance was in place for medicines prescribed to be taken "as required". This informed staff why this medicine had been prescribed, under what circumstances it should be used and how frequently. This was mainly in place for commonly known pain relief medicines. This ensured the use of these medicines could be monitored and the frequency between doses regulated.

There were appropriate arrangements in place between the service and the person's GP surgeries to keep people safe where their health needs required monitoring and treatment plans adjusting. For example, where the dosage of medicines had to be altered according to people's blood results. There were consistent monitoring records maintained, for example the monitoring of people's blood sugars, for people with diabetes. A regular weekly visit by one of the local GP's, which most people were registered with, ensured their medicines were regularly reviewed. Similar arrangements were in place with other GP surgeries.

Prior to the inspection we received information of concern relating to poor staffing numbers and people's needs not being met because of this. This information related to day time staffing only.

The staff on duty were seen to be responding to people's needs. There were mixed comments about when people received the support they needed. One person told us staff responded to their needs. They said, "On the whole, they're (the staff) not too bad". Another person said they had to wait "a long-time" for help. They said "they (the staff) are rushed off their feet." Another person told us staff helped them to have a bath or shower but also said, "They can't always oblige when wanted. I might have to wait a few hours but it's when they've got sufficient staff". A relative told us sometimes the staff seemed short in number but also said "they cope". A member of staff said, "Quite a lot of the time, for example most weekends and often during the week, there are not enough staff. We just have to muck in and work together as best we can. The residents still get attention". Staff told us the registered manager aimed to have seven staff on duty each morning and this was confirmed as correct by the registered manager. Minutes of a staff meeting in January 2015 stated the registered manager had acknowledged the need for seven staff to be on duty in the morning but had said "it was not always possible" and they would look to recruit more staff. Some people had complex needs and particular risks that needed to be managed to keep them safe. When discussing some of these needs, one member of staff said, "When numbers (of staff) drop to four or five it becomes very difficult".

We reviewed the staff rosters (care staff and nurses only) and the number of staff acknowledged as needed had not always been provided. The dementia care unit's staffing numbers were consistent and staff confirmed they were appropriate. Rosters for three weeks between January and February 2015, for the main part of the care, showed that the recognised total of staff required had been achieved for 6 out of 21 morning shifts. Although some people told us

# Is the service safe?

they had to wait until staff were available, no-one stated this had been a problem for them. Care records, observations and comments from people told us people's needs had been met.

We also reviewed an audit of the accidents/incidents that had taken place in January and February 2015, such as falls. One person had experienced eleven falls in a four week period. One member of staff said, "Some people need one to one and there aren't enough of us for that". They gave the needs of this person as an example of when people required additional one to one support, this could be enough to "tip the balance" between what staff could safely cope with and when it became difficult. For this person and others, records showed that appropriate risk assessments were in place. Records also showed that appropriate actions had been taken to reduce risks to people.

People's risks had also been managed in the least restrictive way. For example, when the person who experienced numerous falls wanted to walk, staff ensured that they could do this but with one to one support to prevent further falls. Staff were observed to be very busy but we also observed staff responding to people's needs as and when people needed help.

People were protected from abuse because the service's policies and procedures were designed to safeguard people. Staff had been trained to recognise abuse and what to do if allegations of abuse were made. The service's safeguarding procedures linked in to the Local Authority's wider safeguarding protocols. Safeguarding concerns were shared with other relevant agencies who were also responsible for safeguarding people. People were protected from those who may be unsuitable to care for them. Staff recruitment files showed that robust recruitment practices were followed. There were appropriate staff disciplinary processes in place, which had been used to further protect people from poor or unsafe staff performance. People's human rights were protected in relation to any form of discrimination which could amount to abuse or psychological harm. Staff were aware of how to contact external agencies and knew how to raise concerns they may have about the service.

People lived in a safer and cleaner environment compared with when we inspected in June 2014. One person told us that their room was "cleaned virtually every morning" and said "they put the hoover round and dust." We re-visited all the areas that had previously been of concern to us. These had been improved either through refurbishment or better on-going maintenance arrangements. For example, some areas now had washable floor covering and the main shower room had been totally refurbished. The floor covering had been renewed and was now properly adhered to the floor. There were no cracked and missing tiles with dirty exposed grout. The seal around the base of the toilet had been renewed. Some similar refurbishment had taken place in some bathrooms attached to bedrooms. For example, one wall where the paint had flaked and bubbled due to a problem with damp, had been tiled. Some of these improvements were still work in progress but the areas could now be effectively cleaned.

New cleaning schedules had been introduced and had been adhered to. These included an on-going rotational schedule for deep cleaning, for example where furniture is pulled out and areas behind cleaned. Arrangements for rotational carpet cleaning were also in place and carpet cleaning had been recorded as completed. Areas of high risk, for example where it was known that spillages of urine were more frequent, were checked and cleaned more frequently over a 24 hour period.

Where cleaning was the responsibility of the care staff the standards of cleanliness were not as high. For example the armchairs in the lounges had food debris under seat cushions. We were informed these were cleaned every night by the night care staff. However, the food debris found would indicate these had not cleaned overnight. One member of staff told us there were four staff on duty at night to attend to people in the main house as well as the dementia care unit. They told us if people required supervision and care during the night this would always take priority over night-time cleaning tasks.

The service's Infection Control Policy had been reviewed in December 2014. Guidance in this policy corresponded with the practical arrangements taking place. For example, cleaning products, recorded in the policy procedures for use in various situations, were in stock and staff had a good understanding of what they should be using and when. The member of staff responsible for leading the domestic staff told us all of their staff had received a thorough induction training, which had included an awareness of the relevant policy and procedures.

Good

# Is the service effective?

## Our findings

A visitor told us their relative had been very poorly when they were admitted but staff had "done wonders". Another visitor described their relative's quick transfer from hospital when the hospital was in urgent need of beds. They told us their relative's needs were assessed on admission to the service. They said they had been "impressed" with how staff had supported their relative's recovery. A further visitor said, "I'm very pleased with the way (reference to relative) is looked after. They're happy, so I'm happy". People we spoke with felt the staff looked after them well.

People had access to specialist health care professionals when referred through the GP. These included speech and language therapists, physiotherapists and mental health specialists. They also had access to professional foot care, eye care and dental services. Records showed people were supported to attend health related appointments.

People were cared for and supported by staff who had the skills to meet their needs. Staff were observed making skilful interventions. Staff showed a willingness to learn more and were supported to do this by the registered manager. Staff had been encouraged to take further qualifications and improve their knowledge and skills. This was particularly evident in dementia care. A member of staff told us they had monthly supervision meetings with the registered manager. Records showed that staff had received these support sessions as well as a yearly appraisal. These appraisals gave staff an opportunity to discuss, with the registered manager, their aspirations, achievements and general performance. Another member of staff said these meetings were "meaningful". Best practice guidance was obtained from visiting health care specialists as well as from some staff who either took a lead in areas of care or who had taken additional courses or qualifications.

People's consent was sought before care or treatment was given. Some staffs' knowledge about the detail of the Mental Capacity Act (2005) could be improved. Despite this, people who lacked mental capacity were protected because the Mental Capacity Act (2005) code of practice was adhered to. The majority of senior staff had been provided with training on the subject and one member of staff had done further training to be able to advise other staff. Staff were aware, that where people were unable to consent to their care and treatment, best interests processes had to be followed.

Records showed, where people could not make specific decisions about their care or treatment, these were made for them and in their best interests. These decisions, where needed, had been made by appropriate and relevant people such as the involved professionals and with consultation of appropriate representatives. Where possible people were involved in this process.

The registered manager was aware of the Deprivation of Liberty Safeguards (DoLS) and where necessary they had acted in accordance with legislation. This had involved making referrals to the Local Authority ('the supervisory body') under DoLS where it had been thought necessary. No one was currently subject to a DoLS authorisation. A review of the levels of control and supervision people were in receipt of had been carried out in line with the alteration in legislation following the Supreme Court Judgement Review in March 2014. However, misleading advice had been given to the registered manager about how to make relevant DoLS referrals in relation to this. Clarification on this matter was sought by us during this inspection. The Local Authority subsequently provided the correct guidance to the registered manager who told us they would take the required action.

A record was kept of who held what type of Power of Attorney. Senior staff were aware of who should be consulted and who should be included in best interest decisions relating to people's care and treatment.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders were in place for some people. These were kept in each person's individual file for easy access to share with attending ambulance staff or other relevant people. They had been signed by the person's GP and they recorded if the order had been discussed with the person or a representative.

People were protected against unlawful restraint. Staff were aware this was not to be used unless in emergency situations where no other form of intervention would keep people from harming themselves or others. The service's policies relating to this required a review as they were not relevant to the current services provided. The registered manager had already noted this and told us these would

Good

# Is the service effective?

be re-written. Staff expressed a wish for further training in managing challenging behaviour and in the use of diversional techniques. Despite this, staff were very aware of what may cause challenging behaviour to be exhibited or what may cause distress in a person. One member of staff said, “I always wear my hair up working in here (the dementia care unit), because it agitates (name of person) if I wear in down”. A health care professional told us the staff were good at managing complex mental health needs that could at times be challenging and which other service’s would not have been able to manage.

People received help to eat their meals if they required this. Support was provided in a dignified way and in an unrushed manner. One member of staff was allocated to the dining room to help those that came down for breakfast. People could have their meals in their bedrooms if they preferred. Most people at lunch time ate in the main dining area or in the conservatory. People were given a choice of what they wanted to eat. A relative said, “Meals are nice, (name of person) wouldn’t eat, now they’re eating more. If they don’t like something they are always given something different”. Most people ate their meals with enthusiasm and appeared to be enjoying the food. However, people’s requests were not always taken into account. One person asked for a small portion and was given the size portion that seemed to be the same size as everyone else's. This person said the amount of food on the plate “put them off” but they ate what they could. Another person made reference to this and said, “It’s too much, I keep telling them”. We noticed that many plates contained uneaten food when they were collected. In these cases people’s requests were not being acknowledged. Another person complained of a sore mouth and a member of staff said they would return with some gel to put in their mouth. This did not happen and the roast dinner that the person could not manage was removed without, in this case, a soft alternative being offered. When we questioned this practice another member of staff told us that alternatives were usually always offered.

Risks to people losing weight were monitored as people were weighed either monthly or weekly according to the level of nutritional risk. Regular visits by local GP’s ensured people received dietary supplements as required. Where people had lost weight, kitchen staff were alerted to this. The lead cook had recently completed additional training on how to fortify different foods. This was done through the addition of dried milk, butter and cream to certain foods as well as providing full fat milky drinks. Other necessary diets were also catered for.

Good

# Is the service caring?

## Our findings

One person said, "I like the staff they're always happy with me and they're always nice to me. They've never said anything nasty to me". Another person said, "They are extremely pleasant and seem to go out of their way if you want anything, they are fantastic". A relative told us they were "very impressed with the caring attitude of staff".

People were treated with kindness and compassion. A member of staff in the middle of a busy lounge noted that one person's clothes were stained. The person was quietly and kindly encouraged to follow the member of staff to the bathroom so they could help them to wash and change. This was done in a way that did not attract the attention of people around them and in a way that maintained the person's dignity. Another member of staff had observed a person to be uncomfortable with pain. The member of staff checked with a nurse to see if the person was due pain relief, but it was too early for a further dose. The member of staff then sat with the person until they settled and became calmer. Some people who lived with dementia or a mental health problem shouted out at staff, but staff responded each time in a kind and patient way. When people repeated themselves several times over, staff responded with equal patience each time. Staff demonstrated that they understood this was not something the person could help but was part of living with dementia. People were treated with respect and they were not belittled.

People's privacy was maintained. Staff usually knocked on people's bedroom doors before entering. Although this was not the case, on one occasion, when we were talking to a person in their bedroom. Staff were aware of the need for confidentiality and discussions about people's care were carried out quietly, between staff, or in the nurses' office with the door shut. Records about people's care and treatment were kept in a secured room.

People were made to feel that they mattered. Staff took time to respond to people who spoke with them, even if they were busy and were just passing. An example of this was when people came out of having their hair done, by the hairdresser. Staff made particular efforts to tell people how nice they looked. Staff used people's preferred names and one person proudly told us the staff called him "Sir" which we later witnessed. One person was very good at painting and staff had asked someone from the community to come and work with this particular person. This person's artwork was displayed on a corridor wall and titled (person's name) Gallery.

Staff were able to tell us about people's particular likes, dislikes, habits and behaviours. They knew the people well and this was demonstrated in the very individual approach staff had towards each person. In the dementia care unit it was easier for staff to be even more flexible in their care delivery because it had fewer people. Staff were better able to fit around the routine's of those who lived there more easily. One person was seen eating a meal outside of the main designated meal times. A staff member told us the person "had just not been hungry earlier". There were other examples of very person centred care in this unit.

Care records showed that relatives and representatives were kept well informed of events or deteriorations in people's health. However, regular reviews of the care plans with either the person or the person's representative were not well documented. The records showed where explanations about people's health, treatment and care had been given to them or if more appropriate to their representative.

Independent Mental Capacity Advocates (IMCAs) had been involved where situations had arisen and the person who lacked mental capacity had required independent advocacy.

There were no restrictions on visiting. Visitors told us they felt welcomed and one visitor felt they were "not just tolerated" when they came to visit. One relative said," The staff are kind, courteous , they always offer me a cuppa".

People were supported to be independent. Where people were able to use the community independently and safely they were free to do this. This involved support with transport; the service had its own mini-bus. People were able to use the garden independently or with support. This applied to people who lived on the dementia care unit. Care records stated what people wished to remain independent with. They gave guidance to staff on areas of care where it would be beneficial for the person to remain as independent as possible. Staff recognised that people who lived with dementia needed to be supported to retain the skills they had and for their care practices not to de-skill people.

Good

# Is the service caring?

People were able to practice their preferred religious faith. Staff told us a local Vicar attended for Holy Communion every month and at other times if people want to see them. Some people were visited by their own local priests and one person confirmed that their own Roman Catholic priest came to see them.

Requires Improvement

# Is the service responsive?

## Our findings

We were aware of call bells ringing consistently throughout the inspection and staff responded to these. We were aware of some call bells ringing for longer periods of time; five minutes plus. We were not aware of any accidents or incidents not being responded to. In fact as we arrived an emergency call bell had just been responded to. A person had fallen and staff required additional help which arrived quickly. We wanted to review the call bell print out to see how quickly staff responded to people's call bells. This was not possible because the system's print out was not working. Several days of print out was seen to illegible. There were some issues with the call bell units and how the activated calls were displayed which hampered staffs' abilities to sometimes respond to these effectively. Staff expressed a frustration and resignation to what they said had been on-going problems, which, they said had been reported to the registered provider. We spoke with a representative of the registered provider about the current state of the call bell system, which was potentially putting people at risk. The representative informed us that they were unaware of any issues with the call bell system, that there was no reason for the issues we described to be arising and they would get these resolved. This task was handed over to the maintenance person to resolve.

The service had a complaints policy which we reviewed and the complaints procedure was visible within the home. We were told people were also given information about how to make a complaint on their admission. One person told us they had made a complaint to the registered manager and confirmed it had been resolved to their satisfaction. A family member told us they would take any concerns or complaints to the registered manager. Another person explained their family had raised some areas of dissatisfaction, which had still not been addressed but said "they do not want to rock the boat". The registered manager told us that concerns and complaints received about specific people receiving care were recorded in the relevant person's care file, along with how these were addressed and responded to. Although we were signposted to some recordings of issues received, without a central record of concerns and complaints to refer to, it was difficult for us to assess if all concerns and complaints had been managed correctly. If complaints were specifically investigated by the registered manager, a record of these and the investigation was held in a separate file.

Compliments were kept by the registered manager and shown to us. These described appreciation for the care and support staff had been given to those that had received the care and their families.

The service had a policy on advocacy which stated that information on this could be provided on request. There was no information or signposting about advocacy displayed for people who may want support without alerting staff to this fact. The registered manager told us they would alter these arrangements and make this information available without people needing to ask for it.

Many people who lived at Euroclydon did not have the mental capacity to be involved in their care planning or to be involved in reviews of their care. However, staff told us, where possible, they involved people or their representatives. One person said, "They're supposed to talk to me about the care plan but they've been busy". A relative told us the family had been involved when the care plans were written but they were unsure about the review stage. This relative went on to say, "They let me know if the medications change or something happens".

Information about people's life histories, their interests, preferences and what had been important to them had been collected and recorded. This helped staff to plan care around the individual person. This information had been predominantly gathered by involving family and friends. Care plans reflected this and there was an emphasis in the care plans on people's individual choices and preferences. People were able to maintain relationships with people who were important to them and were encouraged to carry on with interests or find new interests.

People had access to arranged activities six days a week. Two designated members of staff shared the hours that were specifically allocated for activity provision. The service had an activity champion who linked into a forum which supported activities staff to promote meaningful activities in their own services. The aim of the activities provided at Euroclydon was to give people opportunities to mix with others (if they wished to), retain people's skills, bring enjoyment and provide some people with new opportunities. It was explained that the activity that someone was engaged in had to be meaningful to that individual. One member of staff said, "We try the best we can to give people a choice. When they first come in, we usually give them a couple of weeks to settle in. We try to identify their interests, promote them and encourage them

Requires Improvement

# Is the service responsive?

to try something new, which they might find interesting. It's about knowing the person, writing the care plan (the activities care plan) and then working on it. You don't force anybody". This aim was seen to be happening in practice and a wide choice of activities were on offer. Some had come about through people expressing a particular request or interest. An example was given to us where one person had shown a particular interest. A external group of people had been contacted to provide the activity and they now visited on a regular basis because so many other people repeatedly enjoy it.

Specific activities were designed to stretch people's mental agility and some were designed to promote physical fitness. There were activities carried out on a group basis such as music based activities, quizzes and games. People were also supported to do things on their own and there were activities provided by external entertainers and visiting specialist groups. People who remained in their bedrooms were visited by the activities staff at least once a week and sometimes more frequently. Staff told us "quite often they just want to chat". One person told us the care staff never had time to "just chat" to them.

Good

# Is the service well-led?

## Our findings

One person said they would go to the registered manager or deputy manager with any concerns they had, they said "they both help me a lot". One member of staff said, "We all get on really well on the whole". One staff member described the registered manager as "approachable" and another member of staff said she was "very approachable and lovely".

The registered manager told us she operated an open door policy and said that anyone can speak to her at any time. The registered manager was seen out and about talking to staff and following issues up. We did not witness a lot of interaction between the registered manager and the people who used the service, but whenever we spoke about people's care and other issues the registered manager was well informed.

The service had a whistleblowing policy under which staff should feel able to report concerns they have to senior staff, including the registered manager or the registered provider without prejudice or reprisal. Information received by us, prior to the inspection, suggested that people did not always feel able to do this. Minutes to various meetings recorded that the registered manager had regular communication with different groups of staff, people and their representatives. The discussions showed that people and staff were actively communicated with. They were involved in decisions made about the service and how it should run. One member of the care staff confirmed that all staff were able to contribute to the staff meetings. They said staff were able to express their ideas and these were listened to, openly discussed and considered. The latter demonstrates an open and inclusive style of management.

The registered manager told us that through active communication with the staff and by making sure she was available and approachable, she remained in touch with staff behaviours and practices. The registered manager and deputy manager were aware of the service's key challenges, risks and strengths. Staff were aware of their expectations and their responsibilities and were supported to meet these. Arrangements were in place to monitor staff performance. Staff told us the registered manager encouraged them to "better themselves" by taking further courses or qualifications or applying for promotion. The registered manager told us this was part of building an effective and knowledgeable team, which ultimately improved the outcomes for those who used the service. This demonstrated that there were resources and support available to drive improvement.

There were also arrangements in place to address poor performance, attitudes and values that did not promote the service's overall aims and vision.

The registered manager told us they were in contact with the registered provider's representative most days. A weekly meeting with this representative ensured that the registered provider was kept up to date with the service's main issues and progress. This meeting assessed the registered manager's performance by the checking and signing off of previously agreed action plans. A review of budgets took place and discussions on longer term expenditure and improvements took place.

Quality monitoring systems were in place to help protect people from unsafe care and treatment. The monitoring systems ensured that the services the registered provider stated would be delivered, were delivered safely and consistently. We could not see how all concerns and complaints were effectively audited as no central record of those received was held. The registered manager however told us these were audited and we saw a completed audit record. They also told us all complaints were discussed with the registered provider.

We reviewed a selection of other audits and action plans, some of which were current working documents. On-going audits were used to identify shortfalls and monitor the progress of previously implemented actions. Actions plans were used to structure the management of new actions which arose from the auditing process. These actions were agreed on between the registered provider and registered manager and had led to improvements in the service. These actions included the considered views and ideas of the people and staff.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>People were not protected against the risk of unsafe administration of medicines.<br><br>Regulation 12(1) and 12(2)(g).<br><br>(Corresponds to regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines). |