Bupa Care Homes (BNH) Limited

Pendean House Care Home

Inspection report

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Tel: 01730887566

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Pendean House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care, as a single package, under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home provided care for older people, some of whom had dementia. Some of the people were admitted on a short stay basis and were receiving support from the local hospice team. The home had 34 rooms and was registered to care for up to 40 people. The home is set over two floors and had passenger lifts, between the floors.

The last comprehensive inspection was on the 26 and 31 May 2016. At this time the home received a rating of 'Good' overall but required improvement in the 'well-led' domain. A breach of legal requirement was found, relating to oversight and governance. This was followed by a focused inspection on 12 September 2017. This inspection looked specifically at the 'Well-led' domain. At this inspection the overall rating was 'Good' and the legal requirements had been met.

We inspected Pendean House Care Home on 26 July 2018. We brought forward this comprehensive inspection due to information of concern we had received. This information related to the management of end of life care. During the inspection we reviewed the care people received at this time. We found some omissions in the paperwork and assessments. However, people were receiving appropriate and compassionate care and staff were delivering symptom management, under the guidance and support of the Macmillan team.

We reviewed personal risk assessments and the documentation that described the care people required. Some of the risk assessments had not been updated to reflect people's current needs. The care plans were not always person-centred and did not fully identify the care people required. This could impact on the care people received, as there was insufficient information in the documentation to determine what support and care a person needed. You can see what action we told the provider to take at the back of the full version of the report.

During the inspection we reviewed how medicines were managed. Staff had received relevant training and there was a regular audit in place. However, we saw some errors in the prescribing and recording of the delivery of medicines, which had not been identified by the audit process. One person was meant to have two different nutritional supplements prescribed on the medication administration record (MAR). However, one type of supplement had been written up in two separate areas of the chart. Some of the paperwork relating to topical medicines (creams and lotions) and instructions relating to drugs that are given as required (PRN), were missing from the MAR. The impact of this on the people was low, as the nurses had been giving the correct supplements and were aware of when and how to administer the topical and PRN medicines. However, both the management of medicines and audit system, which should have identified the errors, are areas that require improvement.

There was a system for recording accidents or incidents that happened within the home. However, the paperwork was not always fully completed, which would make it hard to determine if there were trends or issues that required addressing. The manager and staff co-operated with the local authority and there was a safe guarding and whistle-blowing policy. There was a complaints procedure and it was seen that any complaints were reviewed and investigated.

There was an audit and quality assurance system. However, this had not identified errors and omissions in the paperwork we reviewed, for example with the management of medicines and the lack of person-centred information, within the care assessment and planning documents. After the concern relating to standards of care, the management team had made an action plan to address the issues identified. However, the oversight and governance of the home is an area that continues to require improvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive ways possible; the policies and systems in the home supported this practice. People within the home told us that the staff were caring and respectful. People were helped with their communication needs and staff asked for consent before completing any care.

There was a system for determining how many staff were required. We received mixed comments from people about the availability of staff. Some people told us that care was provided in a timely fashion, but others mentioned occasions when they had to wait. At the time of the inspection two new members of staff were being orientated in the role. We were advised, by the registered manager, that after their orientation the home would have a full complement of staff. We were also advised that the home routinely had more people on each day than the dependency score indicated.

We similarly received mixed comments about the quality of the food, even though people were given choice and felt able to ask for alternatives to the menu. We observed a meal-time experience. This was a quiet affair and some people would have benefitted from more encouragement and support from the staff.

People's privacy and dignity was maintained when receiving personal care. Staff aimed to promote and maintain people's independence. There was a comprehensive activity programme in place. This included activities within the home and a range of excursions and events. The activity team also saw people on an individual basis. The activities contributed to people's well-being.

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

The registered manager was approachable and actively sought ways of gaining feedback from people and their relatives. Staff felt supported and enjoyed working together as a team. The registered manager had also established links with the local community.

There was a clear system in place for ensuring new staff were suitable for the role. There was a process for orientating new staff. There was also a programme of training for all staff, to ensure they had the necessary skills to care for people. There was a system in place for providing staff supervision.

The home was clean and tidy and there were infection control protocols and policies in place. The environmental risks were managed appropriately. The home was adapted to suit the needs of the people. There was a large garden and a vintage reminiscence room.

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

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 home was not consistently safe.

We identified errors in the medication administration record (MAR), including a duplicated prescription and a lack of documentation relating to topical and PRN medicines.

Personal risk assessments did not always reflect the current needs of people. There were omissions in documentation relating to accidents and incidents.

There was a dependency score for determining the number of staff required. There was a comprehensive system or staff recruitment.

The home was clean and environmental risks were managed appropriately.

Is the service effective?

Requires Improvement

The home was not always effective.

People were not always provided with the necessary encouragement and support during meal-times.

There was a training schedule in place for all staff. There was a system of staff supervision.

Staff had a good understanding of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safe-guards (DoLSs).

People had access to other health-care professionals, according to their needs.

Is the service caring?

Good

The home was caring.

People were treated with kindness and respect.

People were given choices and their independence was maintained.

People's privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

The home was not always responsive.

Care plans were not always person-centred and not all care needs were identified in the documentation.

People, receiving end of life care, received appropriate care and were supported by regular visits from the local Macmillan team. However, the documentation did not reflect all their care needs.

There was a daily programme of activities and a diary of events, including trips outside of the home.

There was a complaints procedure and any complaints received were responded to.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Audits and systems of governance had failed to identify areas of concern and sustain improvement.

There was a registered manager in post, who was supported by the provider's management team.

There were formal systems of feedback, including resident and staff meetings and suggestions were acted upon.

Staff felt able to raise any concerns they had with the management team and told us they were happy in their work.

Pendean House Care 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 26 July 2018 and was unannounced. We carried out this comprehensive inspection due to information of concern we had received. The inspection consisted of three inspectors and an 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.

Before we did the inspection, we reviewed information we held about the provider. This included the notifications the provider had sent to us. A notification is information about an important event the provider is required, by law, to tell us about. We also reviewed the information the provider has sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some information about the service, what the service does well and improvements they plan to make.

During the inspection we observed interactions between staff and people. This included observing a meal-time experience and the administration of medicines. We spoke with five visitors and eight people about the care received. We also spoke with the registered manager, the regional director and quality manager, five care staff, the chef, an activity coordinator and a visiting health-care professional. We reviewed assessments and care plans relating to nine people. We also reviewed five staff recruitment folders and additional files relating to staff training records, accident and incident reporting, audit and quality assurance systems and environmental checks.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at Pendean House Care Home. One person stated, "Absolutely, the staff are excellent." Relatives were also confident that people received safe care with one telling us, "She is safe and looked after." Staff also assured us that people were safe within the home.

We asked people if they were happy with the delivery of their medicines. One person told us, "it is always on time," and another explained how staff had reviewed their medicines and arranged for an alternative prescription. After describing the situation, they concluded, "I have faith in them." However, we found the management of medicines required improvement.

We observed a medicine round and reviewed the medication administration records (MAR). On one MAR we saw that a nutritional supplement had been prescribed on the 9 July 2018. Turning over the page the same nutritional supplement was prescribed again, once more dated for 9 July 2018. Both prescriptions had been signed for by staff. We asked the nurse about the duplication. They advised us that the second prescription had been written incorrectly and referred to a different nutritional supplement. The nurse and registered manager assured us that the person had received both supplements correctly, but this could not be verified by the MAR.

Some people were prescribed medicines which were taken when the person required them (PRN), for example pain killers and inhalers. There were PRN protocols in place for some but not all of these medicines. Some people were prescribed topical medicines (creams or lotions). It is good practice to have a body map detailing where the medicine should be applied. These were present for some but not all of the medicines. The impact of the prescription error and gaps in the paperwork was low, as the nurses were aware of how and when to give these medicines. However the management of medicine needs to be improved, to ensure that people continue to receive the appropriate medicine at the appropriate time.

Medicines were stored appropriately and there were systems in place for the ordering and disposal of medicines. People also had the choice, on admission, as to whether they wanted to remain independent in taking their own medicines. This was clearly documented in care notes.

Nurses and senior carers were trained in the delivery of medicines and received annual updates. The management had already produced an action plan, to improve the current system. There was a medication audit in place, which was completed regularly. However, these had not identified all the concerns we found on the day of inspection.

Accidents and incidents were recorded. However, the method of recording was not always thorough, and we noted some gaps in the paperwork. Poor paperwork may mean that trends are not identified and risks may not be managed appropriately. Some of the action plans following falls were lacking in detail. Two of the entries recorded that the staff actions had been to tell the person to ring their bell for assistance. Only one record had a manager action recorded. We were told that accidents and incidents were discussed in management meetings, which reduced the impact of the gaps in the paperwork. However, the quality

assurance process had not ensured the initial paperwork was completed to a high standard.

Staff received safe-guarding training. There was a "Speak up Champion" within the home, with the aim of encouraging staff to raise any concerns they may have. We were also told of the "Listen up" initiative, which again was aimed at encouraging communication between staff and management.

The provider used a system to assess the dependency of people, so that staffing levels were sufficient to meet their needs. The registered manager told us they routinely had more staff on duty than the system indicated. One person said, "There's plenty of people. There's someone for every job." However, people told us different things, in relation to staff responding to bells or requests. One relative told us, "As soon as he rings the bell, someone comes; there's no delay." However, one person commented, "Yesterday it took three attempts to get my teeth cleaned… They kept coming and saying, 'I've got someone to bathe', or 'someone's on the toilet'." One relative described a difference in care received at nights and at weekends. They mentioned one incident, "I spoke to one of them who was feeding her far too quickly one night … as though it was just something they wanted to get done, so they could get on with something else." Another also commented that the time of day impacted on staff response time, with one stating, "It depends on the time of day." We asked staff whether they had enough time for people. One member of staff told us, "Most of the time we have enough staff." Another commented, "We are busy sometimes but the residents are safe and get choices." On the day of the inspection bells were responded to promptly and care was received in a timely fashion. They had recently had a few members of staff leave. Two new nurses were on their induction on the day of the inspection. During this change over period some of the staff were working longer hours, to cover the vacancies. The registered manager advised us that when the two new members of staff were fully orientated they would have a full complement of staff.

There were personal risk assessments in place. Staff explained that these were completed on admission, then updated monthly, or if there were any changes. We reviewed the risk assessments. People had risk assessments, including assessments related to risks of pressure area damage and falls. These had been completed on admission and there was evidence of monthly reviews. However, one person's condition had changed significantly, placing them at higher risk of falls and skin damage. The last recorded assessment was on 1 June 2018 and the impact of their deteriorating health was not fully reflected in the paperwork. There were personal evacuation plans in place (PEEPs). These detailed the level of support people would require if there was an emergency and the building needed to be evacuated.

During our inspection we viewed people's rooms, communal areas, bathrooms and toilets. The home was clean, tidy and odour free. There was a cleaning programme and one person commented, "They seem to be cleaning a lot." There were supplies of personal protective equipment (PPE), for examples gloves and aprons and staff were seen to use them correctly. The manager had recently reintroduced the clinical risk assessment tool. If anyone had an infection, this was now included in this daily discussion.

The home had maintenance staff and the environmental risks were managed well. Equipment was serviced at appropriate intervals and there were regular checks of the oil, electrical and water supply. At the time of the inspection one of the lifts was not working. A temporary ramp had been created to help people access the second lift safely. There were also contingency plans in place.

We reviewed the recruitment process. The appropriate checks had been made to ensure new staff were suitable for work within the care industry. This included checking their employment history, a reference check and a Disclosure and Barring Service (DBS) check. Prospective staff also had a formal interview. Documentation confirmed that registered nurses also had their registration details checked with the Nursing and Midwifery Council (NMC), to ensure they had the relevant qualifications.

Requires Improvement

Is the service effective?

Our findings

People were seen by one of the senior staff prior to being admitted into the home. One person told us, "They spoke to me, one to one," and a relative confirmed, "He expressed his needs and his little quirks." Staff assessed people's care needs when they first came to the home and completed relevant documentation. The documents included a discussion about a person's physical needs and did provide some details relating to their emotional, social and spiritual assessments. However, some of the documentation was sparse and lacking in detail. The manager informed us that this had been identified and there was an action plan in place to improve people's records. We were told that they did not accept hospital discharges either late in the afternoon, or on Fridays, to ensure that the staff had sufficient time to admit them and check they had the correct medicines and equipment.

The home had a four-week rotating menu. This was aimed at ensuring people had the correct nutritional balance in their diet. People chose their food each day. We asked people if they enjoyed the food in the home. Once more we received mixed comments. One person told us, "It's lovely, very nice," whilst another stated, "The food is poor… I asked for chopped, cooked vegetables. It wasn't cooked properly, I couldn't eat it." A relative told us, "It's institutional food. She likes it, but she doesn't love it."

We observed a lunch time meal. On the day of the inspection there was a minced meat or curry on the menu. This looked appetising. The minced meat was served with a choice of vegetables and the curry came with different accompaniments. The main meal was served in the kitchen and brought to the people. There were circular tables in the room laid with colourful tablecloths and contrasting plates. This can help people who are visually impaired or who have dementia. The lunchtime was a quiet affair. Two people required assistance with eating. One person started to eat independently, when encouraged by staff. Another person did not start their meal. Two members of staff offered this person encouragement, at different times. However, at the end of the meal the person had not eaten their dinner. The lack of consistent support and encouragement, from staff, impacted on the lunch-time experience.

The chef told us that when people were first admitted to the home they received a food preference sheet. This included any allergies, likes and dislikes and if they had special dietary requirements. We asked people if they had a choice regarding the food and if they could choose alternatives. One person told us, "If you don't like something, you can ask for anything." Another relative told us that they could request additional food outside of mealtimes. They told us, "He'll ask for ice cream at 12 at night and he gets it." During the meal we saw one person having an alternative to the other people. The food was also a regular topic in the Residents' meeting. Following feedback lamb was included on the menu. The home had also started themed nights, where food from different countries were served.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive the care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. People's mental capacity was noted on the admission documents. One person had a DoLSs assessment. The rationale for this was documented and there was evidence that the application process had been checked with the relevant authority. The mental capacity assessment was completed appropriately and had been discussed with the person's representatives. There was a policy detailing the process staff needed to follow and staff we spoke to were aware of their responsibilities. One member of staff informed us, "I've had training on the MCA. I know about consent."

During the inspection we observed people being given choices about their care and how they wanted to spend their day. One relative told us, "They listen to what relatives say, but it's the person who is consulted most of all, they take most notice of their views." One member of staff confirmed, "We make sure people get choices." Within the welcome document there were also details of the local advocacy service. These services aim to ensure that people's rights are safeguarded and their views and wishes are considered, prior to any decisions being taken about their lives.

People had access to health care professionals, as necessary. The local GP visited weekly. One relative told us, "He came the first day she was here and spent time with her and got a sense of where she is." The home also had regular visits from the Macmillan team. This is team of specialist doctors and nurses, who provide expert advice on symptom management, during end of life care. Within people's care notes there was evidence that other teams were regularly involved, for example the speech and language team (SALT). We also saw evidence that they followed up any concerns. One example was an issue identified by an optician which was referred to the GP for consideration. The person was later referred to an ophthalmologist for assessment.

There was a comprehensive system for staff training. We asked people if they felt confident that staff had the knowledge and skills to deliver appropriate care. One person responded, "Definitely." There was a system in place to ensure that staff received relevant training. One member of staff advised us, "There are no issues with training, it is of a good standard and thorough." They went on to give a specific example of how the training was both practical and relevant, telling us, "We put each other in the hoist to see what it is like for the residents." Another member of staff gave us a list of training they had received, listing, "MCA and DoLSs, safeguarding, dementia and challenging behaviour." The manager also assured us that training would be provided to staff if they were due to admit a person with specific needs. They gave the example of arranging refresher courses if they were admitting someone who was unable to eat and drink and required feeding via a tube. They advised us that it was important to ensure staff were up to date and confident in the delivering care to people.

New staff had a period of orientation. This involved a formal induction that was based in the classroom then a week of shadowing more experienced staff. During the period of shadowing they also received specific information relevant to the home, for example details about the fire equipment. One member of staff commented, "I had a three-day induction for training, then shadowing for a week. It definitely prepares you."

Staff require ongoing support to help them continue to develop. Supervision provides staff with individual support and provides time for them to voice any concerns they may have. The last supervision for care staff had been in April 2018. However, staff told us that they would like supervision to be more frequent and to have a more formal structure. One member of staff stated, "Supervision is not regular enough." These comments were discussed with the manager. We were advised that staff had other opportunities, outside of supervision to raise any concerns, for example during staff training and meetings. However, they agreed to review the provision of supervision, to ensure it was meeting the needs of all the staff.

Care was delivered over two floors. There were two passenger lifts, although at the time of the inspection one was waiting to be repaired. A temporary ramp had been built so that people could get to the other lift. There was a selection of communal areas for people and a large, welcoming garden. One person told us, "The building is wonderful and the garden is exquisite." One relative said people could choose their room and bring in personal effects, "They've been very good about getting him a bird table and bringing his chair here from home. Before he moved in they gave him a choice of 3 or 4 rooms. They took him round and showed them to him. He chose one on the ground floor, overlooking the garden." We saw bedrooms which were decorated with people's furniture and personal effects. There was also a vintage reminiscence area, which was full of old memorabilia, for example old records and sewing machines. Contact with things from the past can benefit people with dementia as it can help stimulate memories. These items were sometimes used in group talks and discussions. There was a list of improvements planned for the home. This included wheel chair accessible routes in the garden, refurbishment of the therapy room and a dedicated hairdressing salon area.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. One stated, "The staff are wonderful," and another commented, "Everybody is so friendly and helpful." One relative commented, "Some of them are exceptional."

We saw people being treated with care and compassion. Relatives told us that staff gave compassionate care. One relative commented staff were, "very patient with her," whilst another commented, "(Staff) have a sense of humour with her." We saw examples of this caring approach during the inspection. We observed a nurse administering medicines. They were gentle and reassuring in their approach and took time to talk to people. We also observed the friendly and engaging interactions between the people and the activity team and the pleasure people got from the positive comments and encouragement they gave. One member of staff told us, "You can have a laugh with the residents, I think they enjoy seeing us and we keep them company," going on to say, "We lift their spirits and it's rewarding."

A health-care professional told us that staff provided compassionate care which recognised the emotional needs of people. They described one occasion when the home had arranged a candlelit dinner for one of the people to share with their spouse. They told us staff were "very accommodating with trying to help with (their) psychological well-being." They also continued to tell us the difference a recent outing had made to the person, stating it was the, "best thing to happen to (Name) for weeks." Staff also told us that preserving people's sense of self was important. We were told how one person had planned a family party. They realised that their accessories did not match their proposed outfit. The staff went to the shops to purchase accessories that would make the outfit complete.

People were given choice regarding their daily routine and how they spent their time. On admission people were asked about their preferred time for waking up and when they liked to take a wash. Staff also told us the importance of offering people choices. One member of staff stated, "People are free to do whatever they want." Another commented, "We offer all sorts of choices to people around everything, just like I would want it myself." Another told us they would offer choices about clothes and drinks rather than just presuming. The staff also aimed to preserve people's independence. One stated, "I encourage people to walk and ask them if they want to walk today and what they want to do. You don't do anything that the residents don't want you to do." Another commented on the satisfaction they gained from seeing people become more independent, with their assistance. They stated, "I encourage people to be independent. Little steps at a time, doing it in stages. It's awesome to see when people start doing things for themselves."

We asked people if they were treated with respect. One person stated, "It's like family; affection is what it's about." A relative assured us, "The staff are genuine. They don't talk down to people. They just talk normally, they speak as though they are just another person, just older than them." There was a discrimination policy in place and the staff commented about the need to treat everyone equally. One member of staff stated, "There is no discrimination between staff or residents. We get supported around equality and diversity." Within the welcome book there was a comment about people's spiritual needs and a list of the local churches. The home hosted a monthly Communion service and we were told that a local priest visited one

person, according to her wishes.

People were also treated with respect and their privacy and dignity was maintained. People told us how staff gave them privacy during personal care, commenting, staff were, "Very respectful." This was supported by comments from staff. One member of staff told us, "We always knock on doors and cover people when giving care." Another commented, "We always knock on doors and respect whether someone wants a male or female carer." People's confidentiality was also maintained and there was a system in place to ensure personal information was stored securely.

Relatives were also made to feel welcomed and included in people's care, according to the person's preferences. There were regular events aimed at the whole family and visitors were made to feel welcome. One person said, "They are involved my son and daughter…they speak to them and they speak to me." A relative also told us they had confidence that staff would keep them informed of any change, stating, "They phone me if there is an issue."

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that the care received was personal and based around their individual needs. One relative stated, "They really know her as a person." Another described how the care changed according to the needs of their relative. They stated, "She's better since she's been here. They change, adapt as she's improved. They don't just keep treating her in the same way." A member of staff also told us, "We get to know people through contact with them. We find out what they like and dislike and we share information with staff."

This inspection was brought forward because of concerns we received relating to end of life care. As part of our inspection we reviewed the care people received at this time, to determine if people were receiving appropriate care, that met their needs. The home had close links with the local Macmillan team and had an arrangement to admit people in need of end of life care. The Macmillan team visited regularly, to advise about symptom management. One visiting health-care professional told us, "I haven't had any concerns with Pendean. Happy with the level of symptom management." The staff had had training on end of life care and they had the 'six steps accreditation' from St Wilfred's Hospice. This programme is designed to improve care provided in care homes, from the point of diagnosis to bereavement. People were involved in decisions relating to the care they wanted to receive, as they approached the end of their lives and advanced decisions were documented in their care records. The manager explained, "If a syringe driver goes up, it will be her choice." A syringe driver is a device used to deliver medication for symptom management and is often used as people enter the last days of their lives. We were also told that if someone died this was acknowledged and spoken about with the other people within the home. The staff were proud of the care they provided at this challenging time, with one telling us, "We provide excellent palliative care."

Different documentation was used, dependent on how long the person was likely to stay in the home. If the person was initially admitted on a short stay basis, they used their admission document to record the person's needs and risk assessments. If the person stayed for longer than three months, a full set of care plans were completed. People who were admitted for end of life care often had the short stay documentation. The visiting health-care professional told us, "Their needs are complex, that is why we are admitting."

We reviewed one short stay person, who was admitted with deteriorating health. The admission document had been completed two months prior to the inspection. As the person's needs had changed some of the information within the admission document were now out of date. As they did not have dedicated care plans it was hard to determine the person's present care needs. This could result in them not receiving appropriate, or complete, care. One example related to their mouth care. Due to the person's condition and general health, they had a high risk of a dry mouth and consequent infection. The admission document did not state if the nurses had checked their mouth. The lack of care plans also meant there were no instructions about actions to be taken, to reduce the risk of further infection and promote comfort. We were told the person was receiving mouth care but this was not documented in the daily records.

We reviewed other people's care records. Another person was recorded as needing support with "complex

decisions." There was no further information to determine what these decisions may be regarding, the extent of the support required, or who should be the providing the necessary support. There was also a comment that the person required assistance to transfer between bed and chair, to reduce the risk of skin damage. The daily records did not document if this had been done.

We asked staff their opinion about the care plans and documentation. One told us, "There are gaps in the care plans, such as gaps in pressure care assessments." Another commented, "Care plans don't have a lot of information in them. Sometimes we can't get all the information we need." This lack of person-centred detail could affect the quality and consistency of the care given. This was discussed with the management team. We were informed this had been identified as an area that required improvement and staff had been booked onto a care plan refresher course.

This lack of individualised care plans is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 which requires clear care plans, which include goals and review dates, be developed and made available to all staff.

Staff considered people's communication needs. A communication assessment was completed on admission. The song books used in the activity were in large print, to help the visually impaired. The activity team also described how they read to people, who had trouble reading. The staff gave examples of how they had developed ways of communicating, using sign language, with one person who found it hard to communicate verbally.

There was an activity programme. This was discussed at residents' meetings to enable people to give their feedback and make suggestions about what should be included in the programme. The rota showed reflexology, hairdressing, quizzes and reading aloud were provided. Most of the activities happened in the gardening room. This room had shelves of books and games, an area for the hairdresser to use and a small kitchenette. There was an activity team who organised and ran the programme. Activities were available seven days a week, morning and afternoon. One person told us, "I like the singing and the quizzes and that sort of thing." The activity team visited people in their room to tell them what was happening and arranged for them to be helped to the gardening room, as necessary. On the day of the inspection we observed the singing group. People were supplied with song books. The songs were cheerful and many were popular during World War Two. The leader was engaging and encouraged people to participate. Some people sang solos, and it was clear people were enjoying the activity. The group were encouraging and praised the singers.

There was a regular programme of events. This involved trips outside of the home, for example, a recent pub lunch and also larger events, for example a recent vintage garden party. The visiting health care professional advised us the team were, "good at organising events." They celebrated specific occasions, giving the example of the haggis being piped into the dining hall for Burns Night. The manager advised us that the programme of events was sent out to relatives in advance to enable them to attend.

The activity team also visited people in their rooms. They explained that sometimes people were less able to attend the organised activities, or expressed a preference not to. One person confirmed, "I don't take part, that's just me." The activity lead told us that when they visited people in their rooms they often just spent time chatting to people and offered to do practical tasks for them, for example, delivering post or writing birthday cards.

The home had a complaints procedure and responded to concerns raised in a timely fashion. There were also ways for people to give feedback and we saw a copy of the customer feedback form. We asked people if

they felt the staff listened and responded to concerns. One relative told us, "We talked to the nurses about her problems with eating. They were very responsive." Another commented, "If you suggest something they have daily meetings and discuss it. Your ideas are discussed, you don't just say something and it goes nowhere."

Requires Improvement

Is the service well-led?

Our findings

People and relatives made favourable comments about the home. One person stated, "It's a wonderful place…I was lucky to be sent here." Another told us, "I don't know how you could fault it." This feeling was echoed by relatives, with one telling us, "It's good. I would give it four stars, it would be five, but that's impossible," and another saying, "It's absolutely marvellous."

There was a system of audits and quality assurance measures. These included reviewing infection control measures, settings on pressure relieving mattresses and checking for any omissions in documentation. The management team had a daily clinical walk around and a weekly clinical risk meeting. The aim of these was to improve standards and ensure high quality care was maintained. They included discussions about specific people and their care needs and identifying and reviewing any gaps in the daily records. However, during the inspection we identified errors in the medication administration record and lack of detail in the paperwork relating to accidents and incidents within the home. We also noted that some care plans and risk assessments did not contain sufficient person-centred detail. These had not been identified or addressed by the audit and quality assurance process.

A recent safe-guarding concern had been investigated by the local authority. The management team had cooperated fully with the safe-guarding team and had established action plans, to address the issues identified, as part of that investigation. This included discussions with the carers to improve the quality of the daily records and sending nurses on a care-plan refresher course. The registered manager told us they were keen to learn from the event and continue to improve the care provided within the home. The manager was aware of the requirements under the Duty of Candour. The Duty of Candour is a regulation that providers must adhere to. Under the Duty of Candour providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

At the time of the inspection there was a registered manager in place. On the day of the inspection we also met the regional director and quality manager. We asked people if they had contact with the registered manager. One person told us, "Always at lunchtime, they ask if everything is all right. I could go and see them if I wanted to." A visiting health-care professional reassured us they, "Always found them approachable." The manager told us, "My door should be open and I will drop things if a resident wants to see me."

People told us they felt the staff were approachable, with one telling us, "They are uniformly helpful." We asked people and relatives if the carers worked well together as a team. One relative stated, "They do. It's especially impressive with the regular staff; they hardly need to communicate, they've worked together so long." Another commented, "You go and see staff and if they can't help you, they find someone who can."

Staff told us they worked well as a team and took pride in the care they provided. One stated, "We support each other and have personal pride in what we do." Another commented, "I like working here, there is a good atmosphere." The staff felt supported by the manager with one telling us, "The manager is really understanding and you can go to her with anything and she sorts things out." Another described the manager as, "very good and approachable."

The registered manager told us that they had sufficient support from the provider. They had been supported to complete the revalidation process with the Nursing and Midwifery Council (NMC). The NMC requires all nurses to go through a revalidation process which ensures they have sufficient knowledge and experience to continue to practice safely.

The registered manager encouraged feedback from people within the home. They commented that the home was "very resident led," going on to say, "Quite rightly residents tell me what they want." There were formal methods for people to comment on the service provided and make suggestions about future activities and events. There were regular residents' meetings. Following this they put the outcome on the "You said, we did" board. There had also been a recent resident's satisfaction survey. One of the outcomes from this was that people wanted to re-start the residents' committee. This had been acted upon and was booked for the following week. The manager was keen to get feedback from relatives but had been told by the people within the home that they did not want them included in the residents' meeting. They were consequently in the process of arranging a separate relative's meeting. The manager also arranged staff meetings. This was arranged in different staff groups, so that the topics discussed, were relevant to those who attended. Some staff did comment that they wanted a more formal structure for giving feedback, as part of supervision. This was discussed with the registered manager.

The manager was keen to develop links within the local community. They discussed the recent garden party where they had hosted 85 guests. They also mentioned a community project they were planning which would involve working alongside local people to create a community garden.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured care plans were available to staff involved in providing care 9(3)(b)