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Lakenham Residential Care Home

Inspection report

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Ratings

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

Overall summary

We carried out a comprehensive inspection on 17, 21 & 24 September 2015. The first visit was unannounced. The second two visits were announced because we wanted the provider to be available so they could contribute information and we wanted visitors to know we were available to speak with.

We last inspected the home in December 2014 and found breaches in the regulations relating to: recruitment of staff, person centred care, staffing and the governance of the service. The inspection report was not published until May 2015 and the service was rated 'Requires Improvement'. The provider sent us an action plan

Summary of findings

following that inspection. We found during this inspection that three of the breaches were now met but one breach was not and we found some new concerns.

Lakenham Residential Care Home provides care and support to older people some of whom have been diagnosed with dementia. There are three places commissioned by the local authority to provide people with respite care. This means there can be quite a quick turnover of people using the service. The home does not provide nursing care and can accommodate a maximum of 28 people. At the time of the first inspection visit there were 22 people living at the home.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service has a registered manager but they had not been in day to day control of the home for several years. They had not completed the process to have their name removed from the register of managers.

The management of medicines in the home posed a risk to people, such as not having their medicines available to them when needed.

People were not sufficiently protected from risks because of the way the service was managed. There was not clear leadership or oversight of the service to protect people. Our May and December 2014 inspections also found breaches with regard to management of the service.

People were not protected because adequate servicing and checks of the premises had not been undertaken. Regular fire alarm checks had not been done since June 2015, portable appliance testing had not been carried out since 2013. There were risks within the home's environment which had not been assessed: a radiator which was hot and could cause scalding, wardrobes which could be pulled away from the wall and therefore at risk of falling on people. This meant that people were not always safe and risk was not monitored and managed, as part of good management arrangements.

The Care Quality Commission was not always notified of incidents so they could make judgments about risk at the service.

Staff had not acted to gain authorisation to deprive people of their liberty where a person was subject to continuous supervision and control, such as monitoring people's movements. This was because the provider was not aware of a Supreme Court judgement which had widened and clarified the definition of deprivation of liberty.

People's rights were not upheld because family members were making decisions on their behalf without the lawful authority to do so.

Our December 2014 inspection found recruitment practice to be unsafe. This inspection found recruitment practice was improved and checks were undertaken on all staff who had joined the home since we received the provider's action plan.

People received regular drinks and nutritious meals through the day time period and food and fluids were available on request during the night time.

Staff and management were kind, caring and considerate of people using the service. One person's family said, "The girls here are lovely. They genuinely care. They treat mum how you would want her to be treated".

There were enough staff to meet people's needs. Staff received training in their roles and regular supervision of their work through one to one meetings with the provider.

People's emotional needs were understood and met, such as staff supporting a person needing attention and reassurance. Staff were very responsive and ensured they gave people the attention they needed. People were supported to present in a clean and dignified way.

Activities and social interactions with people gave opportunities for friendships and achievements. The arrangements for entertainment were improved because the television and music system had been replaced and an activities worker had been employed.

People's views had been surveyed and responded to. Complaints were investigated and followed up. People and their family members were consulted and involved in decisions about care and treatment.

Summary of findings

There were seven breaches of regulation. You can see what action we told the provider to take at the back of this 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?
The service was not safe.

Improvements were needed with the management of medicines to make sure people living in the home had safe treatment.

Risks within the premises were not always assessed or managed so that people's safety was optimised.

Recruitment practice had improved. Checks were undertaken on all staff who had joined the home since we received the provider's action plan.

There were enough staff to meet people's individual needs in a timely way.

Staff understood their responsibilities to protect people from abuse.

Requires improvement

Is the service effective?
The service was not always effective.

People's legal rights were not upheld in accordance with the Mental Capacity Act 2005 and some were being deprived of their liberty without the authorisation required.

People received regular fluids and a nutritious diet in the day time but there was the potential for some people to go long periods between meals or snacks at night.

Staff received training and supervision in their role.

Requires improvement

Is the service caring?
The service was caring.

People received kindness, respect and their dignity and privacy were upheld.

People were treated with compassion and staff were quick to help and support them.

Good

Is the service responsive?
The service was responsive.

People's individual needs were assessed, planned and responded to by staff who understood them.

People had a variety of activities which gave their life meaning and purpose.

Complaints were investigated and action taken to make improvements.

Good

Is the service well-led?
The service was not well led because there was a lack of overview and coordination in the way the home was run.

Requires improvement

Summary of findings

Arrangements for the safe running of the home were not effective in that risk was not always assessed and identified risk was not always managed in a robust and consistent way.

Legal responsibilities to notify the CQC of events were not always complied with.

The ethos and culture of the home was one of kindness and caring.

Lakenham Residential 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 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.

We carried out a comprehensive inspection on 17, 21 & 24 September 2015. The first visit was unannounced. The second two visits were announced at short notice because we wanted the provider to be available so they could provide information.

The inspection team consisted of two inspectors, and a pharmacist inspector.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who not could not comment directly on their experience.

Visitors were informed that CQC was undertaking inspection visits on 21 and 24 September 2015. We spoke to six people who lived in Lakenham Residential Care Home, two people's visitors, six staff members, the deputy manager and one of the providers. We looked at three people's care records and medicines administration records (MARs) for all the people living in the home. We looked at three staff recruitment records and at staff training records. We also looked at servicing records, a range of quality monitoring information such as survey results and spoke with six health care professionals about the service. These were a care home's nurse educator, three community nurses a member of the local authority safeguarding team and the community pharmacist used by the home. Following the inspection visits we asked the provider for the quality monitoring policy and arrangements which were in place during our inspection.

Requires improvement

Is the service safe?

Our findings

Safety was not adequately managed at the home.

At our previous inspection in July 2014 we had found people were not always protected from the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. This included delays being reported with the supply of antibiotics prescribed for people. When we inspected in December 2014 we found medicines were being dispensed safely and in accordance with prescriptive instruction.

During this inspection we found that improvements were needed with the management of medicines to make sure people living in the home had safe treatment.

There were delays in obtaining some medicines, particularly if these were ordered outside of the regular monthly ordering cycle. One person's medicines administration records (MARs) showed that one of their prescribed medicines had been unavailable for four days, and another for nine days. This could have caused harm to this person's health. A diary message showed these medicines were needed, but there was no record of what action had been taken in response to this. We saw three further messages relating to the need to order this person's medicines. However, staff had not acted with haste to get the medicines as quickly as possible. Staff contacted the surgery during our visit on 21 September 2015 to ask for an urgent prescription for the two medicines which had run out. Our visit on 24 September 2015 found the deputy manager contacting the surgery again.

Staff said they made regular checks of people's medicines to make sure they had been given as recorded. For example, some tablets were checked every day because staff had identified there had been mistakes with their administration. However we found staff had not recorded the quantities of medicines brought in by one person on their admission and so they were not able to check whether these medicines had been given as recorded. We checked four medicines supplied in standard boxes with the people's MARs. For two of these medicines the amount remaining did not agree with the administration record. Staff were not able to demonstrate people had always been given their medicines as prescribed.

One person had been prescribed a medicine to given weekly, with instructions for it to be given on an empty stomach at least 30 minutes before breakfast (or another oral medicine). Records showed this was often given at breakfast time or after breakfast. Staff confirmed they gave this person all their medicines together and the time depended on when the person wanted to take their medicines. Staff did not know if anyone had checked with a healthcare professional, to make sure the medicine would be effective and safe for the person if the counselling instructions were not followed. This increased the risk this medicine would be less effective and also that other important instructions for its safe use may not be followed.

Staff told us one person may need to be given their medicines covertly. This meant, if the person refused to take their medicines, staff could disguise them in food or drink to make sure they were taken. We saw some general information relating to covert administration kept with people's MARs. This had been signed by the deputy manager, a relative and the pharmacist but did not relate to a specific person's circumstances or name the person concerned. Staff were able to tell us how they gave this person their medicines, either with some food or mixed with a liquid medicine. However there was no written information to confirm this with the person's MARs. This increased the risk that medicines would not be given in a safe and consistent way.

Staff had handwritten some people's MAR sheets, for example if they had just moved to Lakenham from home or hospital. Staff said they would ask a second member of staff to check these records but they did not sign them to confirm they had checked; so staff could not be assured that these checks had taken place. This did not follow the home's medicines policy and could increase the risk of mistakes being made leading to medicines being given incorrectly.

This was a breach of Regulation 12 (1) and (2) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

A bottle of one medicine had been lost. Staff had taken action to investigate and report the incident. Additional checks had been introduced to reduce the risk of further incidents occurring.

Staff said that all the medicines were overseen and administered by senior care staff. An up to date medicines

Is the service safe?

policy was available for staff to refer to. Staff involved with giving medicines had received training and told us they also had checks to make sure they were able to do this safely.

People were given their morning and lunchtime medicines in a respectful way using a safe practice. People were asked if they needed pain relieving medicines which had been prescribed to be given 'when required'. One person told staff the order they liked to be given their medicines and staff followed these wishes.

Records were kept of medicines errors, for example when staff had given a person the wrong medicines. Action had been taken to make sure this was reported and the person was safe. The member of staff had further training and assessment to make sure they followed safe practice and people were protected.

The pharmacy provided printed MAR sheets with the monthly supply of medicines, for staff to complete when they gave people their medicines. These had been completed and showed people had been given their medicines or stated the reason, if they had not been given.

Suitable storage arrangements were in place for medicines. Records showed that medicines were stored at a safe temperature.

The provider said that all the premises and equipment was certificated and there were six monthly reviews but we found safety within the premises was not always well managed. A radiator in a communal toilet area was very hot and could burn if leant against, cleaning chemicals were in a cupboard which was supposed to be locked and free standing wardrobes which could topple. Some people had sufficient mobility to walk around the home, which increased the potential for them to be at risk. For example, stairways where we saw people with walking difficulties and using walking aids unassisted on the first floor landing. The provider sent us a copy of your Health and Safety policy and risk assessments dated August 2015. This covered some hazards but not the risks we had identified. and maintenance worker were unable to find any risk assessments dated since 2003, which related to the home environment. No information demonstrated that such risks had been assessed and mitigated.

The provider was unable to provide documentary evidence that some tests within the environment had been undertaken to safely maintain the environment and equipment. The maintenance worker could not find these documents. They said they had been working at the home for four weeks and were "reorganising the paperwork". Various documents were found over the inspection period but they did not confirm all the servicing of equipment was in date. We therefore gave the provider 48 hours to produce documents to confirm the premises and equipment was safe. This confirmed there was no evidence of recent portable appliance testing (PAT) of electrical goods and the maintenance worker said they were not trained or equipped to do PAT testing themselves. The home's Health and Safety policy, dated 2015 stated that fire alarm checks should be carried out on a regular basis, but there had been no checks since June 2015, when the checks had been undertaken on a weekly basis. Potential risk from Legionella had not been assessed so people might be at increased risk from this infection because necessary control measures were not in place; the provider was unaware they needed to take any action.

This is a breach of Regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's five yearly electrical certificate, hoist and lifting equipment servicing, fire alarm certificate and gas maintenance were in date. There was a fire risk assessment dated December 2014 and chemical safety checks were dated April 2015.

Some people living at Lakenham Residential home were at risk of losing weight, falling and of developing pressure damage. There were individual risk assessments in place for people. These included nutritional risk, falls risk, risks from poor mobility and the risk of pressure damage. However, one person who had been discharged from hospital to the home had not been reassessed by the staff at the home before they returned, to ensure their needs could be met. The deputy manager had received a verbal hand over from the hospital and a hospital discharge letter. The day after the person had returned to the home staff found their needs were much higher than expected. Records showed the staff had informed the person's GP and the district nurses they were concerned they could not meet the person's needs. A district nurse then identified that a specific pressure relieving mattress was needed. The home did not have one readily available and the person developed a pressure sore.

Requires improvement

Is the service safe?

The person's care plan and risk assessments did not describe the person's current needs because it had not been reviewed since their discharge from hospital. This meant the care plan was not accurate for staff to follow. The provider recognised they should have been more proactive.

We attended a staff hand over of information, talked to staff and looked at the person's daily records, where risks to the person were highlighted by staff. However, there was differing information about how often the person should be repositioned, which seemed to vary between 'one to two hours' (the nurses file) and 'two to four hours' (on a board in the care worker's office). If repositioning was insufficient this would increase the risk of the person having pressure damage. Records showed the repositioning time varied. For example, on 22 and 23 September 2015 they were repositioned between two and three hourly. Care workers said they were reluctant to move the person because they were in pain and they needed to sleep. They were in close communication with the GP to manage the person's pain relief so they could follow the district nurse's advice.

This is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our December 2014 inspection we found that not all information had been completed for the provider to consider whether the applicant was suitable for the post. There were gaps in a staff member's employment history. Where a Disclosure and Barring Service (DBS) check had highlighted issues, there were no records to show the provider had gained further information to ensure staff were safe to work with vulnerable people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

This inspection found the recruitment of staff was organised in one file. Potential staff had completed application forms and their applications included a detailed employment history. Each recruitment file had a DBS check. Checks had been undertaken on all staff who had joined the home since we received the provider's action plan.

People told us they felt safe at the home. People had also commented in the home's 2015 survey, in response to the question about feeling safe, "I feel safe"; "Very safe" and "Oh yes."

Staff demonstrated a good understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, staff knew to report concerns to the deputy manager, provider and externally such as the local authority, police and the Care Quality Commission (CQC). Staff said they had received training in the safeguarding of people from abuse and records confirmed this.

The provider understood their safeguarding responsibilities and provided detail about how to protect people from abuse. For example, the subject had been discussed in staff meetings and the provider said he regularly checked staff knowledge about it. There had been a recent occasion when staff had informed the local authority safeguarding adults team of a concern. Their advice was documented and followed by the staff.

The home's policy on abuse informed staff of the types of abuse and how to respond. That response could include consulting the provider's 'Whistle blowing policy' which informed staff how they could alert concerns which might be abuse to other agencies, such as the local authority safeguarding team or police.

Staff worked in an unhurried way and had time to meet people's individual needs. One person said in the home's 2015 survey, "Comfortable, safe and always someone there." People, their families and health care professionals said there were enough staff but sometimes staff "Looked worn out". The provider told us of their difficulty in recruiting suitable staff. They said there had been times when staffing numbers were not the level they wanted and so existing staff had covered staffing shortfalls. Our December 2014 inspection found during the lunch time period staff were rushed. The provider then arranged for an additional care worker to be available over the lunch time period which meant that staff were not needing to rush in order to meet people's needs.

The provider was continuing to recruit additional staff who they felt met the standard they required. The mornings of our visits the staff were: the provider, (as administrator),

Requires improvement

Is the service safe?

one senior care worker and three care workers, a staff member (domestic in the morning, care worker over lunch time and activities worker in the afternoon), a cook and a maintenance worker.

Requires improvement

Is the service effective?

Our findings

People's legal rights were not always upheld.

Relatives were consenting to care and treatment on people's behalf without the necessary legal authority to do so. For example, consenting to the care and support people received. The provider was not able to assure themselves that people making these decisions had Lasting Power of Attorneys or Court of Protection deputyships for property and financial affairs and health and welfare. A Lasting Power of Attorney (LPA) is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if they are unable to at some time in the future. This is similar for the Court of Protection, when someone becomes a 'deputy' to act on a person's behalf. One relative confirmed they had agreed to their mother's care plan. However, they only had LPA for property and financial affairs. For someone to make decision about care and treatment they need to be a LPA for health and welfare. Then they can make decisions about, for instance, where a person should live and medical care. This meant that consent was not being sought in line with the MCA. The home also did not have a MCA policy in place. However, staff were able to refer to the MCA code of practice if they were concerned about a person's capacity to make decisions.

This was a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were people at the home subject to continuous or complete supervision. For example, being closely observed for theirs or others' safety through the use of staff monitoring of their movements and sensor mats which set off an alarm if a person tries to move unassisted.

Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. However, in light of the Supreme Court judgement of 19 March 2014, the provider had not assessed people who may be at risk of being deprived of their liberty. The Supreme Court confirmed that if a person lacking capacity to consent to the arrangements required to give necessary care or treatment is subject to continuous or complete supervision and control and not free to leave, they are deprived of their liberty.

The provider had liaised with the local authority (DoLS) team in the past about needing to put a sign on the lift to say it was out of order to prevent a person accessing it unescorted. The DoLS team did not feel this constituted a DoLS at that time.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time and whether they wanted help with personal care.

Staff demonstrated some understanding of Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. They had also received training on both subjects. There were examples of people's capacity to make decisions about their care and support in line with the MCA. Where staff were concerned a person was making unwise decisions due to a possible lack of capacity, they had worked closely with other health and social care professionals. For example, where a person with dementia could not recall the amount of cigarettes they had smoked in a short period of time. This had resulted in cigarettes being limited in their best interests. There was supporting evidence of how this person's capacity to consent had been assessed and best interest discussions and meetings which had taken place.

Comments about the food were mostly positive. They included, "Quite good food"; "Reasonable and always a choice of sweet" and "Most I like." Two people said there was more than enough for them and it was always delivered hot. The cook said she was adapting the menu because she wanted people to have more choice and variety available to them. They had tried both rice and

pasta dishes; the first time a lot was left but the second time people seemed to enjoy the change. There were lists of people's likes and dislikes and any specialist diets, such as pureed.

The day of our first visit the two lunch choices were fish pie or cottage pie. Staff assisted people to eat and aids to eating were provided, such as plate guards, which promote independence. The day of our second visit people were enjoying a sherry to celebrate a person's birthday. People had drinks available to them throughout the 24 hour period either in their room or the lounge areas.

One person's poor dietary intake was concerning staff. They had been prescribed 'build up' drinks and staff were encouraging them to drink; also confirmed by records. The adequacy of people's diet was highlighted at the handover of information between shifts and clearly documented in their daily notes; it was clear to staff which people needed extra support with taking fluids.

People said their supper was from 5pm and breakfast was after 8am. This was a gap of 14 or 15 hours. The provider said that the kitchen was always open for staff to fetch people food if they asked for food in addition to the set meals provided. Also, that sandwiches and cakes were always prepared in advance. We questioned whether some of the people were able to ask for additional food and the deputy manager said they would look into the situation. On 9 October 2015 we asked the provider what have been done about this. They said, "We will begin today another tea/coffee/ hot chocolate and biscuits/cake round at 8pm where refreshments will be prepared in advance and directly offered."

People using the service and their families commented positively about the care provided. People looked comfortable and well cared for. There was a training matrix which helped ensure all staff training needs were planned. Most training was delivered face to face from a training organisation. Staff told us they were pleased with the training arrangements. We saw records of training in many subjects, such as infection control, moving people safely, dementia awareness, safeguarding adults from abuse and fire safety. Other training was provided by a Care Homes Team Nurse Educator and had included pressure damage prevention, hydration, diabetes and constipation. They told us staff had always been very keen to attend the training sessions. Two care workers described their training as "brilliant". Another care worker said the training was "Very good and indepth."

The provider said all new care staff received an induction to the home. This meant that staff had started the process of understanding the necessary skills to perform their role appropriately and to meet the needs of the people living in the home. Arrangements were in place for new staff with no previous care experience to undertake the Care Certificate, nationally recognised since April 2015 as the best induction standard. One care worker confirmed they had started this.

Newly employed care workers were shown around the home, introduced to people using the service and their care records and then shadowed a senior staff member for a few days, depending on their confidence. A maintenance worker and cook, new to the home, had received a limited induction to the home but were experienced in their particular work roles. The provider said that all staff were included in the mandatory training, such as safeguarding people from abuse, and they would be included in the next training sessions.

Records of staff meetings showed that training needs and staff supervision arrangements were discussed, for example, training opportunities and qualifications in care.

Staff received regular supervision of their work through one to one meetings with the provider. These meetings were used to praise good work, identify where improvement was needed and, one staff member told us, "raise issues." Staff confirmed they were held on a regular basis. Each shift at the home included a senior care worker to supervise other care workers. Where a care worker's competence was in doubt they were more closely supervised until the provider felt satisfied their competence had improved. One example was where a medication error had occurred.

People's weight was monitored and health care professionals were contacted where there was any concern. We saw no evidence of people losing weight which had not been responded to.

Records showed that health care professionals regularly visited people to provide advice and treatment. These included GP's and community nurses who attended people during our visits. A district nurse, prior to our inspection, said they had no current concerns about the home. However, during our visits one person's care needs were

Requires improvement

Is the service effective?

the subject of debate between the home's staff and community nurses due to a difference of opinion over how to deliver that person's care. It is not within our remit to make a judgement about this one case. However, the responsibility for meeting health care needs sits with professional health care workers and not the staff of a residential care home, the registration of which does not include providing nursing care.

People's health and welfare were promoted through arrangements for foot, dental, eye and hearing checks and treatment. The provider said that, if family were not available, the home's staff supported people to attend health care visits. Records showed people had access to health care professionals in support of their health and well-being.

Good

Is the service caring?

Our findings

Literature about the service included the statement: 'Everything we do at Lakenham is in the spirit of the basic Christian principles or respect for all human life, the dignity and worth of every individual and a true sense of care'. We found people were treated with kindness, respect and dignity.

Staff and management were kind, caring and considerate of people using the service. For example, the maintenance worker stopped and chatted to a person who wanted their attention. They spent time putting them at ease; they took their arm and were friendly and helpful. Care workers were observed giving people information, involving them in decisions and working at their pace – unhurried. The provider spent time with a person who was anxious. They said, "One of the key things is love and engagement." At lunch time a care worker said to two people spending time together, "Hello ladies. Would you like to join us for some roast lamb"? They treated them in an inclusive and unpatronising way; with respect.

People and their family members were complimentary about the staff and the care they provided. Their comments included, "The girls here are lovely. They genuinely care. They treat mum how you would want her to be treated"; "Staff are nice, kind. They don't put you down at all" and "Very friendly and you are quite free to do what you want."

People's opinion had been surveyed from May to July 2015 and we were shown numerous thank you cards from people's families and people who had received short (respite) stays at the home. Their comments included: "I have been very pleased with everything"; "I would like to come again whenever possible" and "Mother has settled nicely due to the kindness of staff."

People's privacy and dignity were upheld. Care workers were discreet when suggesting a person should visit the toilet. They made eye to eye contact when conversing with them to ensure they were engaging at their level and the person understood what was being said. People's care plans provided detail about the person as an individual so that care workers knew how to engage with them on a friendly basis and talk about what mattered to them.

People were supported to present in a clean and dignified way; their personal care needs were met through the laundering of their clothes and attention to detail, such as clean spectacles and nails.

When providing end of life care the care workers sought advice and tried hard to make the person comfortable and meet their needs. One person, being cared for in bed who we visited during each of our inspection visits, looked comfortable, clean and well cared for each time.

Good

Is the service responsive?

Our findings

Staff spoke knowledgeably about the people they cared for. They showed a good understanding of the individual choices, wishes and support needs for people within their care. Staff made a very detailed record of each person's day. This included, food and fluid intake, their mood, the integrity of their skin, how they had spent their day and any requirement for health care professional advice or input. The same detail of information was transferred between staff at the hand over between shifts. Each shift included a senior care worker who was responsible for the care delivered. A health care professional said of one of those seniors, "She appeared to be extremely good at her job, providing care on the floor, general day to day management of staff and also undertaking administrative work."

Care workers were seen responding to people's physical, emotional and social needs. For example, one person was provided with a jigsaw puzzle, which they were completing. The care worker said they knew she would enjoy it. Other people had newspapers, puzzles or had made friendships at the home and were chatting. A person received emotional support when they needed it.

The inspection of December 2014 found there was a limited range of activities available to people, a television that repeatedly lost its signal and the music from the DVD player kept 'jumping'. The provider bought a new television, DVD player and employed an activities worker in response to our findings and the request from a person's family. The activities worker had produced an activities profile for each person, building on the information from their care plan and from getting to know them. The information was detailed, for example, "(The person) likes her cup of tea and watching Emmerdale."

A record of daily activities for each person showed how people spent their time in a variety of ways. These included, a film afternoon, bingo, music and movement twice weekly, and regular arts and crafts. People were socialising and engaged in arts and crafts on our first two visits. One resident was helping another with a puzzle, some painted, and some did work with wool. Our third visit found people mixing biscuit mix for baking. One person's family said how pleased their mother had been after a baking session when they received a certificate for the best 'mixer' because they felt they had done something well.

The provider stressed the importance of a good assessment of people's needs prior to admission, adding that it was either themselves or a senior care worker who visited and assessed each person. However, this had not happened where a person was readmitted from hospital. They said sometimes people were returned to the home following a hospital stay without the staff being informed of their discharge and how difficult this could be.

Care plans are a tool used to inform and direct staff about people's health and social care needs. People's care plans recorded their individual needs because they were based on the person as an individual. The care plans covered people's nutritional needs, communication needs, continence, sleep, mobility, personal hygiene, medical history, skin and general appearance. Care plans were reviewed monthly with the person, where they were able to contribute, or their family members were involved. One had not been updated following a change of needs. We were unable to determine if this had a negative impact on their care.

A complaints procedure was displayed in the home but was not placed where it could be easily seen or in a format suitable for some people using the service. The provider agreed and said they would improve it. The provider was available for people to speak with on a day to day basis and was seen conversing with people during the inspection.

People using the service told us they had nothing they wished to complain about one saying if they did they would talk to (the deputy manager) because "She's very friendly". The survey of people's opinion May-July 2015 asked the question, 'Do you feel listened to?'. Most responses were positive one person saying, 'No complaints at all.'

The provider demonstrated how a complaint had been investigated and followed up. Records of one staff's supervision showed their practice had been under regular review as not considered of a suitable standard and the complaint about them then led to their dismissal. The provider also said how information from a person's family had contributed to an improvement in activities for people.

Requires improvement

Is the service well-led?

Our findings

The service lacked effective management because there was a lack of overview and coordination in the way the home was run.

The service had a registered manager but they had not been in day to day control of the home for several years. They are one of the four partners in the organisation. The day to day care was organised by a deputy manager and senior care staff. The provider/partner, who works at the home, described their role as administration, accounting, staff timetabling and staff recruitment. We found that no one person was in overall control to assess, monitor and improve the quality of the service and assess, monitor and mitigate risks.

The provider and deputy manager were visible at the home to people using the service and visitors. No person using the service, their family or staff member expressed the opinion that the home was poorly managed during our visits. People had been asked in the home's 2015 survey, if they thought the home was well-led. Responses included, "Yes wonderful" and "Not always well-led." One staff member said, "Organisation could be better."

The provider said they listened to visiting professionals advice toward quality improvement and some professionals felt able to confirm this. The provider was offered support from the North Devon Quality Improvement team (QAIT) on 19 June 2015. The provider told us in relation to QAIT, "If we ever needed advice or help we would contact them."

Health and social care professionals were asked their opinion of the service. We were told there were repeated concerns about the service which were raised at the time.

The provider had produced a job specification toward recruiting a manager for the home.

We asked the provider for their quality monitoring policy and arrangements. They stressed the importance of people using the service having a positive experience and that they aimed to comply with the Health and Social Care Act 2008 regulations. They added 'Some of our methods are tangible and some are intangible.' Some of the information they collected had led to important information relating to people's needs from which necessary changes could be made, an example being the monitoring of people's weight.

The provider recorded there was learning from 'reports of incidents or occurrences'. However, when we questioned the deputy manager as to how accidents were assessed with view to improving safety they were unable to provide any information which showed monitoring of accidents and incidents in the home. The provider sent us information on their quality assurances processes. However, we found audits had not identified some areas for improvement, in particular with regard to people's health and safety. This included people's medicines not being available, in one case for nine days and fire alarms not tested since June 2015.

This is a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify the Care Quality Commission (CQC) of incidents as they should do. A notification is information about important events which the service is required to tell us about by law. They include notification of incidents, including any injury, abuse or allegation of abuse. One person had fallen with a resulting fracture and another person's behaviour led to the home informing the local authority safeguarding team. Those events should have led to a notification to CQC, as part of the arrangements for protecting people.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulation 2009 (part 4).

The provider was passionate about people's care, the way staff should perform and the home should be run. He told us, "I want staff who want to progress and who have a human heart" and "I want a core of dedicated staff."

The 26 May 2014 inspection found the service was not seeking the views of people using the service by way of surveys. During the December 2014 inspection the provider stated they continuously spoke with people using the service and their relatives and representatives. However there was no other evidence to show what action the provider had taken to improve the way views of people were taken into account in order to monitor the quality of the service. This inspection found that people's opinion about the service had been surveyed and people had therefore been able to comment about the standard of service they received.

Requires improvement

Is the service well-led?

There had been improvements and upgrades at the home. These included all laundry equipment, the redecoration of "many rooms" and additional seats to create an additional seating area in the main entrance hallway.

Staff were strongly encouraged to attend training, supervision and monthly meetings at which information was provided and issues could be raised. The areas covered at the meetings included staff training, safe management of medicines, activities for people and any changes to the way the service was run. Staff told us they enjoyed working at the home. Asked about the culture of the home one said, “We treat everyone as an individual and give them the best quality of life”. Another said, “Homely and not clinical. It’s the relationship between residents and the staff.” They said it was easy to raise concerns.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The premises and equipment were not properly maintained to ensure people's safety.** Regulation 15 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People's rights were not upheld because people were making decisions on their behalf without the lawful authority to do so.** Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were being deprived of their liberty without lawful authorisation.** Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not notified incidents which are required to be notified to the Commission so that risks connected with the service could be assessed.** Regulation (18) (2) (a) (b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessment of risks were not always current to people's needs. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was insufficient oversight through the management arrangements for assessing, monitoring and mitigating to ensure people's health, safety and welfare were protected. Regulation 17 (1) (2) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected through the arrangements for the management of medicines Regulation 12 (1) & (2) (b) (f) (g)

The enforcement action we took:
We have served a warning notice to be met by 1 January 2016.