Maria Mallaband Limited

Oaklands Country Rest 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 11 and 12 September 2018 and was unannounced on day one.

At our last inspection the service was rated as good. At this inspection we found the level of compliance had not been sustained and we have rated the service as requires improvement. This is the first time the service has been rated requires improvement.

Oaklands Country Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Oaklands Country Rest Home is registered to provide care for up to a total of 44 people who require nursing or personal care. The service has a new unit, to provide care for up to 14 people, included in the overall numbers, who have memory impairment or dementia. The home is approximately ten miles west of York, close to the village of Kirk Hammerton. At the time of our inspection there were 38 people who used the service, with 49 percent of people requiring nursing care.

The service had a registered manager who registered with CQC in June 2016. 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.

People who lacked capacity did not receive the necessary prompts, encouragement and assistance to eat and drink to ensure their nutrition and hydration needs were met.

People received compassionate and caring support, but staff were not reviewing care plans and risk assessments on a regular basis even when people's care needs had changed. The quality of the record keeping varied and some care records we looked at were inconsistent or incomplete. This meant staff did not have an up to date record of people's care and treatment.

We found there were breaches to Regulations 14 and 17 in relation to not meeting nutrition and hydration needs and poor record keeping. We gave feedback to the quality manager and the registered manager about our concerns during and at the end of the inspection.

You can see what action we told the provider to take at the back of the full version of this report.

People and relatives told us how happy and satisfied they were with the service. However, we found that there was a lack of strong leadership from the nurses and senior care staff in the service. This meant care

staff were disorganised at mealtimes and the oversight of their work practice was ineffective, resulting in some minor but important lapses in quality care. These included poor documentation of the care being given, a poor dining experience for some people and inconsistency in promoting people's dignity. We have made a recommendation around reviewing staff numbers and deployment in order to meet people's needs, especially those living with dementia.

Staff had completed an induction and attended relevant training to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to talk to health care professionals about their care and treatment. People could see a GP when they needed to and they received care and treatment when necessary from external health care professionals such as the district nursing team and speech and language therapists (SALT).

People and relatives said staff were caring and they were happy with the care they received and had been included in planning and agreeing the care provided.

People had access to community facilities and a range of activities provided in the service. People and relatives knew how to make a complaint and were happy with the way any issues they had raised had been dealt with.

People told us that the registered manager was approachable, open and honest. People and staff were asked for their views and their suggestions were used to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were sufficient staff on duty but their organisation on shift and deployment in the service was poor, which meant people did not always receive a high quality of care.

Medicines were managed safely in the service.

The provider had effective recruitment procedures in place.

People were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People living with dementia did not receive the encouragement and support with eating and drinking that they required.

Staff supervisions were not always carried out regularly, but staff received relevant induction and training. They were aware of the requirements of the Mental Capacity Act 2005.

People received appropriate healthcare support from specialists and health care professionals where needed.

Is the service caring?

Good

The service was caring.

There were some inconsistencies in how people's privacy and dignity was respected by staff. However, feedback from people, relatives and professionals was positive and indicated this was usually promoted to a high standard.

The people who used the service had a good relationship with staff who showed patience and gave encouragement when supporting individuals with their daily routines.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were patient and kind when delivering care, but care and treatment was not consistently documented.

People had access to a range of activities and enjoyed those on offer.

There was an effective complaints policy and procedure in place and people felt their concerns were listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although action was taken by the registered manager during our inspection, their oversight of the service had not mitigated the shortfalls in record keeping beforehand.

There was a clear leadership structure with identified management roles.

The manager had submitted notifications to CQC in a timely way.

People, relatives and staff members were asked for their views on the quality of care and support being delivered at the service.

Oaklands Country Rest 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.

This inspection took place on 11 and 12 September 2018. Day one of the inspection was unannounced and we told the registered manager we would be visiting on day two.

The inspection was carried out by three inspectors and an expert-by-experience on day one. Day two of the inspection was completed by two inspectors. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received feedback from local authorities that contracted services with Oaklands Country Rest Home. This information was used in the planning of our inspection.

We received a 'provider information return' (PIR) in March 2018. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We carried out a Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four people that used the service, eight relatives and two visiting health care professionals. During the inspection we spoke with a quality manager, the registered manager and five staff. We observed staff providing support to people and we observed the interactions between people that used the service

and staff. We looked around the premises and saw communal areas and people's bedrooms.

We looked at four people's care records, including their initial assessments, care plans and risk assessments. We looked at medication administration records (MARs) and a selection of documentation about the management and running of the service. This included quality assurance information, audits, recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

Requires Improvement

Is the service safe?

Our findings

The dependency levels of people who used the service were used to determine the levels of staff on duty. We looked at the dependency tool and checked four weeks of the staff roster; this indicated sufficient staff were on duty over the 24-hour period to meet people's needs.

We observed that people were settled and relaxed in the service. However, we found that the leadership and oversight of staff and care practice by the qualified and senior staff on duty was weak and ineffective at times. We saw that the lunch time experience on Acorn (dementia side of the service) was disorganised and some people were not always given assistance with their meals as needed. At one point in the afternoon on day one of inspection we found ten people sat in the lounge area on Acorn, unsupervised for half an hour. No incidents occurred in this time but there was a potential risk for people to come to harm.

We discussed this with the registered manager who spoke immediately to the member of staff who should have been supervising this area. They also told us that they were looking at staggering meal times on Acorn in order to give staff sufficient time to assist people with eating and drinking. The registered manager and quality manager were aware of the issues with leadership within the staff teams and said staff development was on-going.

We recommend that the service considers the needs of people living with dementia and recheck their dependency tool and scoring in relation to the specialist needs of people living with dementia.

Systems were in place to identify and reduce the risks to people who used the service, but these were not always used effectively. People's care plans included risk assessments. However, we noted that some of the risk assessments had not been reviewed on a regular basis, even when care needs had changed. For example, one person had been using the service for the past eight weeks, but none of their risk assessments had been reviewed including those for pressure damage and nutrition, even though they were scored as high risk. The registered manager said these should be done every four weeks or more often as needed. Our observations showed that appropriate care was being given to the individual. Discussion with the quality manager and registered manager took place at the end of day one of inspection. They agreed that the care records were not always up to date and would speak with staff about this.

There were systems in place for monitoring, recording and reporting accidents and incidents. However, the monthly analysis of incidents did not look at trends and patterns and there was no written evidence of lessons learnt and action taken to prevent reoccurrence. Discussion with the registered manager indicated they would develop this aspect of risk monitoring straight away.

We observed that staff knew how to use equipment and had safe moving and handling practices. For example we saw staff moving a person from a wheel chair into a dining chair. Staff explained to the person what they needed to do and carefully and safely moved that person.

People told us they thought the service was a safe place to live. They said, "The care I get from the people

who look after me gives me no reason to feel unsafe" and "The staff are nice and I have [Name] next door who is my friend and I have an alarm here by my bed if I need help."

Policies in relation to safeguarding and whistleblowing reflected local procedures and relevant contact information. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised and previous incidents had been managed well.

Records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date and fire safety training for staff was completed. Personal emergency evacuation plans (PEEPs) for people who used the service were in place and a summary of these was available for emergency situations. A PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency.

We observed call bells being answered in a timely manner. On one occasion where the bell had rung for five minutes the registered manager responded and answered the call as staff were busy. One person told us, "Sometimes the response is not very good and I have to wait. But generally, they answer in a reasonable time." Another person told us, "Very good staff. There are enough and they look after me and my partner well." We observed that although the service was busy the staff gave people choices about care, whilst ensuring daily routines were completed.

We looked at how medicines were managed within the service and checked people's medication administration records (MARs). We saw that medicines were ordered in a timely manner so that people did not run out of them, were administered on time, recorded correctly and disposed of appropriately. Staff had received training on the handling of medicines. This was confirmed by our checks of the staff training files. We saw that medicine competency checks for all the staff who administered medicines to people were completed every three to six months. People told us that staff always watched them taking their medicines and never left the room until they had swallowed them. This was to ensure medicines were taken appropriately. We spoke with a visiting GP who said they came out weekly to assess people's medicines. They told us, "Staff are very good at calling me out appropriately. I am happy how staff administer medicines and staff are receptive to advice and take it on board."

We looked at the communal areas and a sample of bedrooms (with people's permission). Premises were clean and there were no malodours. One person told us, "My room is clean and they change the bed linen regularly."

Recruitment practices were followed to make sure new staff were suitable to work in a care service. Monthly checks of nursing registrations were carried out to ensure the nurses remained on the Nursing and Midwifery Council (NMC) register and were deemed fit to practice. However, we discussed with the registered manager the need to ensure all documents in the employment files were signed and dated and that where gaps in employment histories had been explored then this was documented. The registered manager assured us that this would be done in future.

Requires Improvement

Is the service effective?

Our findings

People on Acorn did not always receive appropriate help and support with eating and drinking. For example, one person sat for half an hour with their lunch time meal in front of them and then staff took it away without attempting to encourage them to eat. Dessert was served and again taken away uneaten. Staff who spoke with us were aware the person needed support with eating and said there were usually enough staff on duty to support at mealtimes.

Staff did ask people what they wanted to eat, but did not show them what the meals were. People then did not want what was given to them. We observed people walking around and leaving their meals and staff were not around to prompt and encourage them to eat. One staff told us, "We have eight or nine people who need assistance at mealtimes." There were 'grazing bowls' in the communal areas on Acorn and the chef said these were supplied with snacks such as soft style 'crisps'. Milkshakes and other high calorie drinks were also available. We expressed concerns to the registered manager that people were not getting enough to eat.

Staff on Acorn told us no-one was on a food or fluid chart even though we had looked at the needs of people who were at risk of weight loss or poor nutritional and fluid intake. Staff said they did keep records for people who were on fluid 'thickeners', but the records we were given were poorly completed. All staff spoken with demonstrated a good understanding of the need to monitor intake and output where concerns were noted, but we found records were not in place.

We asked the quality manager and registered manager some questions about the missing documents. We asked if one person in particular was on a food and fluid chart as they were losing weight, refusing to eat and was on a high calorie meal and snack diet. The registered manager confirmed that there was no monitoring chart in place. The quality manager said this had been discussed and needed to be implemented for everyone who had lost weight – three people in total. We looked at fluid balance records for four people in the main house. The records lacked consistency in the level of documentation and there was no totalling of input and no output records. Often there was nothing documented on the records to indicate drinks had been given between 3pm and 8.30am the next day.

Staff said they worked with kitchen staff and ensured people adhered to special dietary requirements. However, when we spoke with the chef it became apparent that they had not been updated about the dietary needs of a person who had been in the service for two months and had complex needs.

The evidence above shows there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action was taken by the registered manager in response to our concerns and by day two of our inspection the chef had spoken with the family of the person and had a list of their like/dislikes and specific dietary needs pinned up in the kitchen. Food and fluid charts were in place and staff were completing them appropriately.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Whilst we saw evidence of some supervisions taking place staff told us that they did not receive regular formal supervision, but did have daily support from the nurses and senior care staff. The registered manager acknowledged that this aspect of practice needed some development. We were told that going forward the nurses would provide six to eight weekly supervision with the care staff and ensure it was recorded. Other heads of departments would be responsible for their staff team supervisions.

People were cared for and supported by trained, motivated and skilled staff. People told us, "Staff support me when I have a bath. I was worried when I came here about how it would be like. I have settled very well. The staff know what to do" and "If I have a problem they know how to sort it out." One relative said, "The older staff know what they are doing; I think some of the younger staff because they don't have the experience need to learn more. The experienced staff know how to manage my relative. I have never heard staff say a wrong word or be sharp or rude; that includes all staff." Where possible people had signed their consent to care forms in the care files and said staff respected their right to make choices and decisions for themselves.

Staff said they listened carefully to people who had difficulty communicating and gave them time to talk. They used hand signs, pictorial aids and wrote things down depending on what people found the most effective way for them. Staff told us they ensured people wore their hearing aids if deaf and they cleaned glasses and ensured people wore these where appropriate.

There was a comprehensive induction and training programme in place for staff. Nurses received appropriate training, development and support to fulfil the criteria needed to revalidate their professional registration. Checks on the identity of agency workers were carried out by the registered manager prior to them starting work. All agency staff completed an induction before starting work in the service and a record of this was kept by the registered manager. Competency assessments for nursing staff were carried out by one of the nurses who had completed a mentorship course and also did preceptorship of new nurses. The deputy manager and one of the night nurses also did competency assessments of the care assistants and senior staff.

People had good access to health care professionals. Records of visits were kept in the care files and people had hospital passports in place. One professional who spoke with us said, "I have no issues with the care service or the support being given to people. Staff are responsive and act appropriately on any advice I give them." One person told us, "You can have the doctor anytime. I don't feel well today and I was offered the doctor but I refused and decided to stay in bed."

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 for 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 care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The service was working within the principles of the MCA. We found that people had been assessed for capacity, and there were documented best interests meetings with families and GP's involvement where needed.

The environment was clean, tidy and well maintained. People were encouraged to remain as independent as possible. Appropriate equipment and aids were in place to assist staff when moving and handling or supporting people with their care. This included specialist beds, hoists and sensor mats. All equipment was in good working order and ensured the care being provided was safe and effective.

Thought had been put into the design of the environment in relation to people living with dementia. There was sufficient signage on communal facilities such as toilet and bathroom doors to help people access and use these as needed. On Acorn the corridor on the ground floor was displayed to represent a town street. There were shop windows displaying fashion clothes, a toy shop, and a record shop. There was also a coffee shop which had tables outside and a post office with a large red post box. People sat at the coffee shop tables throughout the day. The street also had hanging baskets of colourful flowers on both sides of the corridor, giving people something to look at and talk about.

People had access to a secure garden area to the front of the premises. The garden had seating and a water feature to encourage people to sit outside in the fresh air. There was a slope down from the lounge into the garden and flat walking around it so people with mobility problems could still access it easily. Acorn lounge was equipped with interactive items such as soft toys and tambourines for people to pick up and use as wished. One person was asleep in the lounge but seven others were alert and waiting to do an activity.

Good

Is the service caring?

Our findings

Staff were kind, caring and patient with people and we were given very positive feedback from people and relatives about the care and support they received. However, we found staff needed to give a little more care and attention to people's dignity at times. For example, we saw one person on Acorn who was left in food stained clothing all day. Their family came to take them out at tea time and they left in the same clothes, which was not dignified for them. Another person was due a visit by their GP and, even though staff knew about this, no attempt was made to take the person to their room. Instead we saw the GP was attending to the person in the corridor.

These concerns were discussed with the registered manager who agreed staff should have given more thought to people's dignity and said they would speak with staff straight away. Observations on day two of inspection found people were dressed appropriately in clean clothes. Feedback from two health care professionals indicated they usually saw people in private when they came in to offer treatment and examine people.

The majority of relatives who spoke with us were happy with the level of communication between staff and themselves. One relative said, "I have no worries about not being informed. I visit most days and the staff tell me all about my relative, 'chapter and verse'." Staff told us, "We inform relatives of any changes to health such as a fall or an accident. We don't always ring them after a hospital appointment unless there are changes to their care." However, another relative told us they had not been contacted about a fall in the service where their relative had not needed hospital treatment. They put in a complaint to the registered manager which resulted in increased vigilance by the staff. An arrangement was now in place that the family was contacted about any issues and this had worked in practice recently. The relative said the new process was working well.

People and relatives told us they found staff attitudes to be kind and caring. One family member told us, "I am very satisfied with the care and support given to my relative. I always find [Name] clean and well presented and I feel they are being well looked after and I have no worries about their care." Another relative said, "Staff all work together to manage [Name's] dementia care needs. They have put equipment in place to manage their falls and staff approach towards [Name] is very caring and friendly."

People had access to call bells and were encouraged to personalise their bedrooms to make them feel more familiar and homely. This included bringing in items of furniture and photographs. We observed that the people could choose to have their doors left open or closed whilst they were in their bedrooms and staff understood their preferences. We spoke with one person who was enjoying sitting looking out of a window. They said they were enjoying the sunshine and watching what was going on in the garden. They had their walking aid to hand and their call bell. They told us their mobility was not good, but the staff were very nice and made sure they were okay.

People and relatives confirmed they had input to their care plans and had a chance to comment on these at care reviews. One relative said, "I am going away but when I get back the manager has arranged for [Name's]

three month review to take place with me." One person told us, "Staff talk to me. If I wasn't happy about my care they would listen and explain things better to me."

The registered manager understood the role of advocacy and had contact details available if anyone who used the service required the support of an advocate. An advocate is someone who supports people, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them.

Care files were kept in a locked room inside a locked cabinet. We noted that staff relocked both doors when taking files out for us. Information files were seen in people's bedrooms, but their personal information was safely locked away. Staff said they understood about confidentiality. Observations showed that conversations between staff and people were appropriate.

People we spoke with thought staff were very caring and helpful and support was always there. We asked people and relatives if they thought the staff treated them with privacy and dignity and were they respectful and polite. They told us, "No rudeness and they always knock on my door. My partner is a shy person about their personal care and they have both male and female staff to help them. They never complain to me about this" and "Staff are kind and polite they always call me by my name. Lovely staff."

We observed staff treating people in a kindly manner and speaking quietly and patiently to people. For example, a person using a walking frame was encouraged to be independent by staff as they moved along the corridor to the dining room. The person stopped because they were tired and staff got them a chair, Staff said "Just take your time [Name] and catch your breath." When a queue appeared in the corridor as people wanted to pass to go into dining room staff explained they would have to move the person so people could pass. This took a little time and patience, but eventually staff managed to do this and explained all the time to the person what needed to be done.

The atmosphere in the home was light and humorous; people looked comfortable with staff and seemed happy to be around them. Staff laughed and joked with people and there was a lot of talk about the dog that was coming to see people that day. We observed most people were well presented had clean clothes and looked reasonably smart. People's hair was nicely combed though some people had no shoes or slippers on.

Requires Improvement

Is the service responsive?

Our findings

Care staff told us, "We complete a 72 hour care plan on admission and then develop more detailed care plans as we get to know the person better. Care plans are reviewed monthly and should involve the person or relatives as appropriate." The registered manager confirmed with us that care files should be reviewed monthly or more often as needed.

We found that care records and risk assessments were not up to date and were not reviewed monthly or when changes to needs were identified. The lack of review and updating of care documentation put people at potential risk of harm as staff did not have an up to date record of people's current needs.

We found that staff were referring people to health care professionals when needed, but advice and treatment from the professionals was not always transferred onto the care plans. We looked at a selection of care records and found that these did not record end of life wishes or decisions as part of people's assessed needs.

People's care files were not being reviewed and updated when care needs changed. For example, in one person's file their risk assessments had not been reviewed since their admission. Their care plan said they should be weighed weekly but this had not been carried out since August 2018. Another file showed the care plans and risk assessments for this person had been reviewed in March, June and August 2018. This did not reflect the monthly updates that staff and the registered manager told us were expected by the provider.

A third person's file documented they had lost 7.4kg or 9.3% of their body weight over the last six months. They were refusing to eat their meals. Staff had sought input from the dietician and GP in the last two months. However, their care plan for nutrition had not been updated since the end of July 2018 and the dietician advice was not recorded on the care plan. Their nutritional risk assessment was last reviewed at the beginning of July 2018 and was rated as high risk, but had not been reviewed since. Their care plan for skin integrity stated the skin integrity risk assessment should be reviewed monthly but it was last recorded in April 2018. This person's records showed they moved from residential care to nursing care in August 2018 but their care plans had not been updated to reflect their increased care needs.

This evidence shows there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we had concerns about the quality of the documentation within the care files this only had a low impact on people's health, as we observed people received appropriate care and support during our inspection. For example, the person above with known weight loss received a fortified diet that was suitable for their swallowing needs. We saw that one person at end of life was clean and comfortable in their bed and received appropriate care on a regular basis from the staff. Staff had consulted professionals about a dignified and pain-free death and facilitated the receipt of anticipatory medicines that could be administered at short notice.

There was a mix of people with both nursing and residential needs in the main house and on Acorn. Many of the people had early onset dementia and struggled with communication. Staff said they took into account people's preferences, likes/dislikes and their beliefs before giving care. One staff member said, "Understanding the person is important, so we can look after them in the way they want to be cared for. This includes having input from their relatives when the person cannot communicate their own needs." People and relatives told us they were able to discuss care and support with staff. One relative said, "I have not seen [Name's] care file, but I am aware they have one. I am not bothered about reading it as staff will always keep me informed of any changes."

The provider complied with the Accessible Information Standard (AIS), which sets out a specific approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with disabilities, impairment or sensory losses. They achieved this by assessing and identifying and then managing people's individual communication needs. There was an accessible information board in the entrance hall which informed people of the different formats available for them to receive information in such as easy read, large print, braille, email and text.

Staff had the skills to support people particularly in relation to their diverse needs on the grounds of protected equality characteristics, and had knowledge about, for example, people's religious rituals and customs for end of life support. Staff made sure people's comfort was maintained by ensuring they had appropriate equipment, medication and personal care to keep them free from pain and discomfort. One person who we met said they were very comfortable in their bed.

Families were made welcome in the service and were able to assist their loved ones with their care and support as wished. A visitor told us, "I cannot speak highly enough about the staff. They [Relative] receive excellent care, the staff love them and are respectful and courteous. I am really happy with the care being given by the staff."

The provider employed a full-time activity coordinator who worked Monday to Friday, and alternate Saturdays. The activity coordinator kept a daily record of activities and said people enjoyed taking part in club activities. The gardening club had just finished due to the time of year and a knitting club had replaced this activity. There was also a baking club. People and relatives gave us very positive feedback about the activity coordinator and said, "They are wonderful, hardworking and passionate about what they do." One family member told us, "[Name of activity person] organised a birthday party for my relative. Residents from both units were invited to attend along with our family. My relative thoroughly enjoyed the day."

During our inspection there was a communion service in-house and ten people attended. Four people said they had enjoyed the service. In the afternoon in Acorn there was a sing-a-long and one person from the main house attended. There was also a person from the dog's trust who had brought a three legged dog to visit the home. This was to see whether the dog would be suitable for the home to foster it and for the dog to come and live at the service. The dog proved popular with people and seemed to settle down very well.

People knew how to complain and who to approach. They said that they would feel comfortable to make a complaint if they needed to. We observed in the reception that there was a complaints procedure on the wall and information was provided to help people understand the care and support available to them. One visitor told us, "Staff have got to know my relative well. Any concerns I had in the early stages about staff getting to know my relative were raised directly with the registered manager. They addressed these quickly and effectively." Checks of the complaints file showed complaints were responded to and duty of candour was met.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager and qualified nursing staff. During the inspection we raised issues about staff deployment in the service and the fact that leadership on the two units appeared to be weak and at times ineffective. The impact of this was seen at lunch time on Acorn when people did not always receive a good experience around support with eating and drinking. We also found times on Acorn where people were left unsupervised in the communal areas and saw two people treated in an undignified way.

The registered manager was working with the quality manager to make changes to the service to improve the quality of care provided. Most of the issues we raised during our inspection had been identified through the provider's audit process and work was on-going to improve things, but these changes had not had time to be embedded in practice.

During our inspection we spoke with the registered manager about the quality of the documentation and records within the service. In this report we have mentioned that records we looked at were inconsistent and incomplete at times. Although we observed staff gave empathetic care, on-going assessment, review and updating documents needed to become a proactive process to take account of and respond to people's changing needs in a timely way. Following our discussion with the registered manager, on both day one and two of inspection, they took swift action to make improvements to the documentation and spoke with staff about what was needed to change practices.

People who we spoke with said "The service is well managed" and "There is a high standard of care and a supportive team of staff." One relative told us, "The service is family orientated. Staff work as a team and there is a good atmosphere. Families are included and there is a close knit relationship between us all." Staff said, "We are well supported by the management team. The deputy manager is great, they are always on the units and know all about what is going on. They are one of the team and very approachable."

Staff were not asked to do tasks they were not confident about completing. The staff training plan showed that all care staff completed essential training and then went on to undertake more specialist training and vocational training courses such as diplomas in health and social care to further develop their knowledge. The registered nurses were supported to maintain their registration through training and personal development. This demonstrated that people were looked after by well trained and knowledgeable staff, who were confident and capable of meeting their needs.

Feedback from people who used the service, relatives, health care professionals and staff was usually obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. The questionnaire information was analysed by an independent company who produced a quality report based on the responses. Where necessary action was taken by the provider to make changes or improvements to the service.

As part of the quality assurance process the registered manager completed monthly oversight and

monitoring reports of wound care, weight loss, infection prevention and control measures and end of life care. There was an annual statement of infection prevention and control in line with best practice. We discussed with the registered manager about introducing 'Learning from events' such as medicine errors or incidents. This is where the service reviews such events and the action they took; to see where improvements could be made and practices changed to ensure the risk of it happening again is reduced.

There were records kept of the quality manager visits to the service. These were detailed and the last two reports for June and July 2018 showed that actions being carried forward were reduced as changes were made to the service. The registered manager carried out quality audits on a monthly basis. Where needed, action plans were produced and completed when actioned.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people were not always met as part of the provision of care by the service. Nutritional and hydration needs were not always regularly reviewed and changes to people's needs were not always documented in their care plans. People who lacked capacity did not have necessary prompts, encouragement and help to eat as appropriate. Regulation 14 (1) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (c)