CareSmart Limited

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

Summary of findings

Overall summary

The inspection took place on 29 and 30 March 2016 and was unannounced. We last visited the service in July 2014 and no breaches of regulations were found.

Kent Farm residential home is registered to provide accommodation with personal care for up to 21 people, many of whom are living with dementia. At the time of our inspection there were 18 people living at Kent Farm Care Home including four people living in The Old Dairy. The Old Dairy is a four bedroom annexe in the grounds of the main house a short distance away, which provides accommodation specifically for people living with dementia.

The service had 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.

People said they felt safe and secure at the home and trusted in staff to care for them. Relatives said they felt the home was safe and secure. However, we identified some environmental risks for people, such as a partially blocked fire exit. There were no personal emergency evacuation plans for people in the event of a fire and no fire evacuation equipment upstairs. We asked the fire service to follow up these concerns further with the provider, which they have done. A fire officer visited the service on 3 May 2016 who said they were writing to the provider to require them to risk assess and review aspects of their fire evacuation plan. They were also advising them of further work needed to upgrade their fire doors to meet current fire safety regulations.

Staff sought people's consent for their day to day care. However, where people appeared to lack capacity, people's rights were not protected. This was because staff did not complete any mental capacity assessments. There were no records to demonstrate staff involved relatives and other professionals in 'best interest' decisions about people's care and treatment. Some people were subject to restrictions on their liberty for their safety and well-being, without the proper processes in place. This was not in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLS).

Staff knew people well and were friendly and supportive towards people. However, people's care was task focused, and organised around routines of the home, rather than in response to people's individual needs and wishes. Care records lacked information about each person, their life before they came to live at the home, or about their hobbies and interests. This meant some care staff did not have all the information they needed to engage in individual conversations of interest to people. At times, there was a lack of stimulation and meaningful activities for people living at the home, which meant people, spent a lot of their time sitting around or sleeping without much to occupy them. An activity programme showed external entertainment was provided at the home, which included, which included musical and reminiscence therapy and regular visits by a massage therapist.

People were not protected because the quality monitoring systems in place were not fully effective, as they had not identified the breaches of regulations found at this inspection.

Most people and relatives were satisfied with the service provided at Kent farm, and said staff knew people really well. One relative said, "No concerns whatsoever, the care is tremendous." Complaints were investigated and responded to. However, two relatives weren't entirely happy with how their concerns were responded to.

People received care and support at a pace and time convenient for them because staffing levels were sufficient. A robust recruitment process was in place to ensure people were cared for by suitable staff.

People had access to healthcare services for ongoing healthcare support. Staff recognised when a person's health deteriorated and sought medical advice promptly when a person was feeling unwell. They worked closely with local healthcare professionals such as the GP, and community nurse, who confirmed staff sought advice appropriately about people's health needs and followed their advice. People received their prescribed medicines in a safe way.

People were supported to improve their health through good nutrition. Staff encouraged people to eat a well-balanced diet and make healthy eating choices. Staff encouraged people to eat a well-balanced diet and make healthy eating choices and to be active, and maintain their mobility. They involved physiotherapists and occupational therapists and obtained any recommended equipment to promote each person's independence and safety.

Staff were aware of signs of abuse and had contact details about how to report concerns to an external agency. Staff had no concerns about potential abuse. Most staff said they would report any concerns internally and were confident these would be appropriately investigated, although one said, they would also contact external agencies directly to make sure. Staff were knowledgeable about people's care needs and received regular training and updating, although we identified some further training needs. For example, in the care of people living with dementia and in understanding Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) safeguards .

We identified five breaches of regulations during the inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

People were at increased risk because environmental and safety risks had not been adequately assessed and managed.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

People received care and support at a time convenient for them because staffing levels were sufficient. Staff had been recruited safely to meet people's needs.

People received their medicines on time and in a safe in a safe way.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff offered people choices and supported them with their day to day preferences. However, where people lacked capacity, their legal rights were not fully protected because staff were not acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005.

Some people were subject to restrictions on their liberty for their safety and well-being, without the proper processes in place.

People accessed healthcare services appropriately, staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were supported to eat and drink and maintain a balanced diet.

Staff received regular training and support through supervision.

Is the service caring?

Good

The service was caring.

People and relatives said they were consulted and involved in decision making about care and treatment decisions.

Staff treated people with dignity and respect and spoke about people with compassion.

Staff were kind and affectionate towards people and knew them well.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Although staff were friendly and supportive towards people, care was task focused, and at times people lacked stimulation.

People's care records lacked details about each person, their interests and hobbies or about their family or life before they came to live at the home.

Formal complaints were investigated and responded to. People knew how to raise concerns, although some relatives were not fully satisfied with how these were dealt with.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People were not protected because the quality monitoring systems in place were not fully effective.

We received mixed feedback about the culture and leadership at the home.

People's, relatives' and staff views were sought and taken into account in how the service was run and examples of suggested improvements were implemented.

Kent Farm 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.

The inspection took place on the 29 and 30 March 2016 and was unannounced. 18 people were living at the home when we visited.

Two inspectors visited the service. Prior to the inspection we reviewed information about the service from the Provider Information Return (PIR). This is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also looked at other information we held about the service such as feedback we received from health and social care professionals, relatives and from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

A number of people living at the service were unable to comment directly on their care and experience of living at the home as they were living with dementia. We therefore 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 could not talk with us.

We met all 18 people using the service, and spoke with four relatives and a friend. We spoke with the registered manager, and with eight staff. The provider was away when we visited. We looked at seven people's care records including medicine records. We looked at four staff records, and at staff training and supervision records. We looked at the provider's quality monitoring systems such as audits and systems for communicating information between staff. We sought feedback from health and social care professionals who regularly visited the home such as GP's and community nurses, and received a response from five of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and secure at the home and trusted staff to care for them. Relatives said they felt the home was safe and secure. A relative said, "I feel mum is safe here." However, we identified some environmental risks for people.

We found the fire escape from the upstairs floor to the ground floor was partially obstructed by storage boxes and the designated fire escape corridor to outside was cluttered with lots of stored goods and equipment. This would make it much more difficult for people to escape in the event of a fire. We raised this with the registered manager, who immediately cleared these areas to make them safe. They said people living upstairs currently would be unable to use this fire escape in the event of a fire, because of their lack of mobility. As there was no fire evacuation equipment upstairs, we asked how people would be evacuated in the event of a fire. The registered manger explained the fire plan was to evacuate people to safe zones on the same floor in the event of a fire, which was confirmed by the fire risk assessment, dated November 2015.

There was no personal emergency evacuation plan for each person, which would show staff or the emergency services what support each person needed to safely evacuate in the event of a fire. We were concerned about these fire safety arrangements and contacted the fire authority, who said they would visit the service. They contacted us to confirm they carried out a visit on third May 2016. They were writing to the provider to require them to risk assess and review aspects of their fire evacuation plan. Also, to advise them of further work needed to upgrade their fire doors to meet current fire safety regulations.

In the lounge area and in two people's bedrooms, portable convector heaters were used to provide additional heating, which were not covered or protected. These represented a burns risk for people, particularly people with impaired cognitive ability, such as people living with dementia. These heaters had not been risk assessed, so these dangers had not been identified. Following the inspection, the registered manager contacted us to confirm all convector heaters have now been removed from use at the home and that all other portable heaters have been risk assessed.

Upstairs, we found a large radiator cover loosely propped against the wall in an upstairs corridor, which was hazardous for people, as it could injure them if it fell over. The cover belonged to a radiator in a nearby bedroom, which was unprotected and felt very hot to the touch, which could represent a burns risk. The hot water in the rooms we checked was warm, with the exception of one room where the water in the hot tap felt hotter than the recommended 44 degrees. In one person's room, the hot tap wasn't working. We made the registered manager aware of these issues and asked them to follow them up and address.

We asked about Legionella controls, (Legionella is a bacteria that can grow in hot water systems which can cause a serious pneumonia like illness). There was no evidence that a risk assessment had been undertaken or that any legionella checks or controls were being carried out at the home. This meant there were no control measures were in place to prevent or reduce the risk of Legionella infection.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

We asked to see the environmental risk assessments but they could not be located. However, they were forwarded to us two weeks after the inspection. They showed two different risk assessment tools were in use, which was confusing and meant there wasn't a consistent approach to managing environmental risks. Some risk assessments used a risk template tool, which showed the level of assessed risk, (high, medium, low) and identified measures to reduce risks; which were dated, signed and reviewed annually. For example, they showed thermostatic valves had been fitted to hot water outlets to ensure hot water in people's rooms was within the health and safety executive's maximum limit of 44 degrees centigrade. Other risk assessments sent were undated and unsigned, so it was unclear who wrote them, when they were written or last reviewed, and the level of risk had not been assessed.

Regular checks of the fire alarm system, fire extinguishers, smoke alarms, and emergency lighting were undertaken. Fire drills were held twice yearly, although they did not include any simulated fire evacuation procedures, which have been recommended by the fire authority.

People's individual risks were assessed, when they first came to live at the home, and were reviewed regularly. For example, one person's falls risks had been assessed and measures identified to reduce their risk of falling. This included the importance of using good fitting footwear as well as detailed moving and handling plans. These instructed staff about how to move and transfer the person safely, including details of any equipment needed. Where people had limited mobility, staff had involved physiotherapists and occupational therapists and obtained any recommended equipment to promote each person's independence and safety. For example, an occupational therapist had been involved in recommending a specialist chair for a person, as previously they had been slipping out of their chair. A relative confirmed the provider had recently suggested they relocate a person downstairs, due to their deteriorating mobility.

Staff confirmed there was had enough equipment to safely support people's care needs such as electric beds, hoist and hoist slings, and pressure relieving equipment. All equipment was regularly checked, serviced and maintained to make sure it was safe for use. Staff undertook safe moving and handling practices in communal areas of the home. For example, staff assisted a person to transfer from a chair to a wheelchair and to use a stand aid, which was in accordance with the person's moving and handling instructions.

People received care from sufficient staff at a time and pace convenient for them. During the day three care staff were on duty and the registered manager, Monday to Friday. In addition there was a cook and housekeeping staff. At night there was one waking staff in the main house, one in The Old Dairy and a sleep in member of staff, available in case of emergencies. The rota confirmed these staffing levels. Where people's needs were increased, for example, when receiving end of life care, staff worked extra hours to accommodate people's needs. The registered manager had also increased staffing levels in the evening in order to ensure people were assisted to go bed at a time convenient for them.

The provider information return completed in December 2015 showed six staff had left in the previous year, and that the home had high agency usage. A relative commented on the number of staff that had left, which they said was a shame for people. Since then three new staff had been recruited, one of whom was undergoing their induction. Where there were gaps because of vacancies or staff sickness, staff worked extra shifts or used named agency staff, who knew people at the home well and had worked there previously. This helped ensure people received continuity of care from staff who had got to know them and about their needs. The registered manager said recruiting the right calibre of staff had become more difficult, and they still had some vacancies, including the post of activity co-ordinator.

Staff received training in safeguarding adults and were able to describe the different types of abuse people may experience. Staff were aware of signs of abuse and had contact details about how to report concerns to an external agency. Staff confirmed they had no concerns about potential abuse. Most staff said they would report any concerns internally and were confident these would be appropriately investigated, although one said, they would also contact external agencies directly to make sure. No safeguarding notifications had been received from the service, and the registered manager confirmed there had been no safeguarding concerns identified since the previous inspection.

People received their medicines in a safe way, which was confirmed by the community pharmacist who supplied medicines to the home. The home used a monitored dosage system on a monthly cycle. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Tablets and other medicines administered were accurately documented in people's medicine administration records (MAR sheets). We checked some people's medicines and found they were correct. Medicines stocks were checked and MAR sheets were audited regularly with action taken to follow up any discrepancies or gaps in documentation.

Accidents were recorded in people's records and showed actions taken to reduce risk, such as in relation to falls. All appropriate recruitment checks were completed to ensure fit and proper staff were employed. All staff had police and disclosure and barring checks (DBS), and checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

The service did not have a regular maintenance person. The registered manager said staff reported faults in a book, and they arranged for repairs to be carried out as needed, which we confirmed. Regular servicing of equipment and appliances were undertaken, for example, hoisting equipment, the stair lift, as well as fire, gas and electrical appliances.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had access to hand washing facilities and used gloves and aprons appropriately. Housekeeping staff had suitable cleaning materials and equipment. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

Requires Improvement

Is the service effective?

Our findings

People, relatives, health professionals said staff provided a good standard of care and treatment. A relative said, "They know her well and understand her" and "They are good at recognising when her health deteriorates." Another relative said the person's health had improved since they came to live at the home.

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 when this is in their best interests and legally authorised under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) safeguards.

Staff sought people's consent for day to day care decisions such as whether a person wanted a bath, shower or a wash. However, where people lacked capacity to make an informed decision, or give consent, staff were not acting in accordance with the requirements of the MCA. There was no MCA or DoLS policy, procedure or assessment framework in use at the home. No mental capacity assessments were undertaken. People's care records were vague about people's mental capacity. For example, terms such as 'memory loss', dementia' and 'can become confused' were used to describe people who appeared to lack capacity or had fluctuating capacity. This meant it was unclear which people lacked capacity, about which decisions and when. There was no information to guide staff about how they could support those people to make as many decisions for themselves as possible. Staff demonstrated a limited understanding of the principles of the MCA and including DoLS and associated codes of practice.

Although families were consulted about people's care and treatment, there was no evidence of any 'best interest' decisions made. For example, in one person's records, a decision was made about how to meet the personal care needs of a person who was sometimes resistant to personal care. Although the approaches suggested did not include the use of restraint, there was no evidence about who was consulted, or if these approached were agreed in the person's 'best interest,' as required by the Code of Practice. This meant people's legal rights were not protected.

We followed up the lack of MCA assessments with the registered manager. They confirmed they had done some relevant training and showed us an MCA information poster they had put in home for staff. They said they would seek the assistance of mental health professionals to undertake a mental capacity assessment, where a specific decision was needed in relation to a person's care and treatment. Whilst there may be complex situations when professional help is needed to assess someone's capacity, this showed the registered manager was unclear of their responsibility for deciding if someone has capacity for a specific decision.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four people lived in The Old Dairy which was locked with a keypad access system, and they could only leave this building accompanied by staff for their safety and wellbeing. However, there was were no person-specific 'best interests' decisions about this documented. The lack of best interest decision-making processes, including around restraint, meant people's legal rights were not protected.

The registered manager had submitted deprivation of liberty applications to the local authority deprivation of liberty team for two of the four people who lived there. No other applications had been submitted, although other people at the home were also under the constant supervision and control of staff and not free to leave.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In The Old Dairy, a stairgate was fitted outside one person's room, which could prevent the person from leaving their room, although no 'best interest' decision was documented about this. When we asked about this, the registered manager said the safety gate was used to ensure the person's safety at night and not to confine them.

New staff confirmed they had undertaken an induction programme which involved working with more experienced staff, to get to know people and to learn about the role. Written induction records were used to confirm the areas covered by the induction. For example, policies and procedures, fire safety, moving and handling. A training matrix showed staff received regular training and updating on safeguarding adults, health and safety, infection control, and moving and handling. The registered manager said they did the practical moving and handling training for staff and assessed staff competencies. However, they had not completed an Institution of Occupational Health and Safety (IOSH) approved 'train the trainer' qualification to do so. This could mean people were at increased risk because they may not be teaching staff the most up to date moving and handling techniques.

Most care staff had qualifications in care and or were undertaking them, so had the appropriate skills to care for people. Other training relevant to people's needs was also provided. For example, pressure area training was booked for April 2016 and the registered manager said they had recently attended verification of death training provided by the ambulance service. Some staff said they needed more training on meeting the needs of people living with dementia, and the PIR showed only one member of current staff team had received training on dementia care.

Staff feedback about supervision was mixed, three staff members told us they had not received any one to one supervision, although some staff had not worked at the home very long. However, they said the registered manager was very supportive and approachable if they had an issue or concern they needed to discuss. We looked at four staff records and found records of supervision in two, one dated February 2016 and the other dated 2013. However, the registered manager said the deputy manager was currently doing supervision with night staff, which was why some staff supervision records were missing. Staff appraisals were not carried out, which meant staff did not receive regular feedback on their performance so any further any training, learning and development needs could be identified, and addressed.

Prior to the inspection, a member of the public raised some concerns with us about the décor at the home. An annual survey in 2015 also included several comments about the décor, one relative said, "It's got a bit tired here and there," which some health professionals had also said. Some areas were in need of refurbishment, particularly the carpet in the hall stairs and landing, which was worn, looked grubby and was fraying in places. The registered manager confirmed the carpet was being replaced the following week. They

also told us about recent redecoration of some rooms such as the quiet lounge and of plans to do further redecoration. However, where redecoration had taken place, there was no evidence the décor had taken into account the use of colour schemes to help people living with dementia find their own room or to identify toilet or bathroom areas independently.

We recommend that the service take further steps, based on current best practice, to improve the environment to make it more suited to the specialist needs of people living with dementia.

There was a lack of dedicated storage at the home which meant some equipment such as wheelchairs were stored in corridors and alcoves. This made it more difficult for people with mobility equipment to move freely around the home. It also gave some areas of the home a more cluttered and institutional appearance. The registered manager said they hoped to convert one of the existing bathrooms into a wet room. This would provide access to a standalone shower for some people, who currently did not have access to one, other than a shower head over a bath.

The registered manager undertook a detailed assessment of each person's care needs before they came to live at the home. People's health care plans gave detailed information to staff about how to manage each person's individual health care needs and any risks. For example, one person was at risk of skin breakdown due to their reduced mobility and poor circulation. Their care plan showed the person was being visited each week by the district nurses who changed their dressings regularly. All advice given to prevent the person developing pressure ulcers was being followed. For example, the person had a pressure relieving mattress, and was sitting on a pressure relieving cushion. They had heel protectors to protect them from damaging their feet. Several people at the home had diabetes and those care plans were specific to the individual's needs. For example, staff had been taught by the district nurse to do 'finger prick' blood tests to monitor a person's blood sugar. Where people's blood sugar readings were too high or too low, staff knew what action to take to ensure to ensure they returned within recommended limits.

People had access to healthcare services for ongoing healthcare support. Staff recognised when a person's health deteriorated and sought medical advice promptly when a person was feeling unwell. Care records showed GPs, district nurses, mental health nurses, a chiropodist and an optician visited the home regularly. Health professionals confirmed staff at the home contacted them appropriately and followed their advice and recommendations. A health professional said staff were always helpful and knowledgeable about the person they were asked to visit. They commented positively on how well staff at the home managed some people's complex health needs and followed up their test results conscientiously. In the provider information return, the registered manager said the deputy manager was working on new guidance for staff and were developing individual dental hygiene plans to improve people's oral hygiene care. We asked about this and were told it was 'work in progress.'

People and relatives were positive about the food choices at the home. One person said, "The food is excellent." There was a choice of menu which people were asked to order from the day before. People said meals were never rushed and they were able to take as long as they like to eat. People had a choice of two main meals each day, from a four week seasonal menu, which was cooked from freshly prepared, locally sourced ingredients. Where a person didn't fancy what was offered, they could have an alternative. Where people had any food likes/dislikes, these were known by kitchen staff. Reduced sugar alternatives and sweeteners were available for people living with diabetes.

People were offered hot and cold drinks and snacks regularly throughout the day. Staff supported some people who were unable to feed themselves independently, to eat and drink. Where people had a poor appetite or were unwell, staff tried a variety of ways to tempt them to eat. For example, smaller meals and

snacks and offering milk shake food supplements prescribed by their GP. Others who were overweight had been supported to lose some weight by agreeing to have smaller portions. Weight charts showed people had been supported to gain/lose weight according to their health need.

Good

Is the service caring?

Our findings

One person said, "All the staff are friendly and helpful," other people's comments included, "Staff are always cheerful" and "They help you a lot." Relatives said, "Staff are fantastic, caring and lovely," "Friendly and professional" and "Compassionate." Relatives said staff involved them in decision making and kept them updated about any changes for the person. A visiting professional said staff were very caring and said the service was, "Very homely."

We observed caring and compassionate interactions between staff and people. Staff and the registered manager spoke with caring and compassion about the people they supported. When a person didn't wish to join others for lunch, several staff attempted to persuade the person. They demonstrated skill and patience, and eventually persuaded the person to join other people in the dining room for their lunch, which they enjoyed. Staff promoted people's independence, for example, a staff member encouraged a person to walk to the dining room using their walking frame. Although initially the person was reluctant to do so, with gentle encouragement the person was able to get to the dining area independently.

Staff spoke about people they cared for with compassion and affection. Most staff interactions with people were caring and good humoured. They knew a lot more about each person than was documented in their care records and staff were welcoming and friendly towards relatives and visitors.

People and relatives said staff treated them with dignity and respect. Staff ensured a person was wearing their preferred clothing and jewellery. Staff discreetly offered people regular support with personal care. Visiting professionals said people were always helped back to their room so that privacy was provided for any discussions and examinations. People were given the opportunity to meet privately with their visitors in the quiet lounge.

Where people had communication needs, these were documented in the person's care records. For example, that one person had hearing difficulties and wore hearing aids in both ears, and needed the batteries changed weekly. Another person was able to understand what staff said, but had limited speech. Their records said, 'Sometimes (person's) facial expression changes to indicate they need to use the bathroom.'

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, such as the person's views about resuscitation in the event of unexpected collapse. The registered manager said some people's treatment escalation plans (TEP's) needed updating, and they had contacted the local GP surgery and were waiting for them to visit to do so. A health professional said staff were advocates for each person in discussions with health professionals about their individual care and treatment needs.

People's religious and cultural needs were supported. For example, a local vicar visited the home every so often to hold a communion service, and an Easter service was recently held at the home.

Families and other visitors were welcomed, at any time, and chatted easily to staff. They said staff kept in regular contact with them provided updates about how the person was doing. People and families, as appropriate, said they were consulted and involved in developing and reviewing their care plans. One person whose care we looked at had signed their care plan to confirm they agreed with it.

Each person's birthday was celebrated with a homemade birthday cake. Photographs on display showed people enjoying recent events such as Christmas and birthdays. One person was supported to re-establish regular contact with a friend, which they were pleased about. This was because a staff member helped the person to respond to letters they received from them.

Requires Improvement

Is the service responsive?

Our findings

Staff were friendly and supportive towards people. However, the care was often task focused, and organised around routines of the home, rather than in response to people's individual needs and wishes.

At mealtimes, people were helped into lunch in a particular order, in accordance with a seating plan for the dining room, which was related to some people's mobility needs. This meant some people were waiting at the table for a while before lunch was served, and one person began to become agitated. People sitting at each table were served their lunch at the same time, so they could eat their meal together.

A staff member assisted a person to eat their lunch, but they did not engage in any meaningful interaction with the person they were helping. Staff used institutionalised terms sometimes, when they described some aspects of people's care and in their records. For example, where a person needed staff to support them to eat and drink, terms such as 'feeder' were used, which did not uphold people's dignity.

People's care records were very detailed about their health care needs but had limited information about the social aspect of people's care. For example, about the needs of each person as an individual, their hobbies and interests. Records lacked information about people's lives before they came to live at the home. This could mean some people were less well supported with their individual interests and hobbies, especially by newer staff or agency staff. This was because staff may not have all the information they needed to help engage people in meaningful conversations of interest to them.

People's daily records gave details about people day to day care needs. However daily entries referred to care tasks completed but didn't give a sense of how each person spent their day. Records had limited information about each person's emotional or psychological wellbeing. One person said they could go to bed and get up at whatever time they wanted and another person said they were served breakfast at whatever time they chose to get up. However, a staff duty book showed there was a list of the order in which staff were guided to get people up each morning. When we asked about this, the registered manager and staff assured us this was a guide only and was flexible. They said people could change their mind and get up earlier or later if they wished. A 'bathing chart' also showed which days of the week named people had a bath. When we asked about this, staff said people could choose a different day or have a bath or shower more often if they wished. They said recently several people had decided they preferred to have their in the evening, which staff had accommodated.

A couple of people were reading a daily paper in the lounge and we heard a person new to the home asking staff if they had any opera music. However, most people did not have the cognitive ability to comment on activities at the home. During the two days we visited, people spent much of their day sitting in the lounge without much to occupy them, and several slept for long periods. Staff came into the lounge regularly and helped people to sit down, use the bathroom or transfer to the dining room. People were not distressed or calling for attention, however, most of the staff interaction with people related to assisting them with care tasks. On the second morning several people were more alert, and one person was reading their paper. However, as there was nothing going on to engage or stimulate people, most people dozed off again after a

while. When the trolley arrived for morning teas and coffees, several people woke up and looked interested for a while, and then fell asleep again until it was time for lunch. This showed there was at times, there was a lack of stimulation or meaningful activities for people.

An activity programme showed regular external entertainment was provided at the home, which included musical entertainment, dementia reminiscence and music therapy as well as flower arranging. A massage therapist, who also offered reflexology, visited whilst we there, which several people enjoyed. The home's website said yoga was offered, but the registered manager said this was no longer the case as people were not interested in this, so it had ceased. A radio in the lounge provided background music for people and the home had a selection of films on DVD that people could watch. However, as people's individual records of social activities were poorly completed, they did not demonstrate people had regular activity or stimulation. For example, the last two entries in one person's social activities record was on the 24 March 2016, and November and December 2015 in another person's.

An internal activity programme showed staff were supposed to provide an activity each day, for example, a staff member did a regular seated exercise class and other scheduled activities included floor volleyball. However, we did not see the scheduled activities take place whilst we were there. For example, on 29 March 2016 staff were scheduled to lead a game of snakes and ladders and to do nail care on 30 March 2016.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the lack of stimulation and interaction with people with the registered manager, who explained the previous activity co-ordinator who worked at the home, had left. So far, they had been unable to recruit a member of staff with the right skills to replace them. The registered manager said one person liked to help out in the dining room and another person was supported to attend a community lunch locally once a month. They also told us about local volunteers who visited a person weekly to keep them company and about another person's relative who regularly visited and plays music for people, which they really enjoyed.

Another staff member said they liked to take people out for a walk nearby when the weather was fine. Previously, the home had a minibus, which was no longer available, which staff said limited the number of trips out people can access, particularly people who needed their wheelchair to go out. The registered manager confirmed, for special occasions, they could hire a minibus. The home also had a vehicle which could be used to transport people to their appointments.

One formal complaint had been received by the home and had been appropriately responded to. The registered manager had met with the complainant to discuss their concerns and had agreed several actions to address them, which were underway. A relative commented that they had to prompt more than once before staff took action about the person's changing needs. Another relative who had raised concerns on more than one occasion and said they had not been entirely satisfied with the outcome. For example, they suggested the person's medicines might need to be reviewed, as they were sleepy, a suggestion they said was rejected without an explanation. However, the registered manager said they had met with the person's relative and discussed these concerns in detail.

Feedback from the relative of a person who came to stay at the home for a period of respite showed they enjoyed the company, visits from the massage therapist and a cheese and wine afternoon. A letter from another relative said the person was well looked after and praised the staff.

An audit of call bell response times in February 2016 showed average response time were within 60 seconds. Where a person lacked the cognitive ability to use a call bell, staff did half hourly checks on them at night, to see if they needed anything.

People's views were sought about various aspects of the day to day running of the home. For example, minutes of a residents meeting on 17 January 2016 welcomed three new people to the home. One person said how happy they were at the home and thanked staff for all they did. People said they enjoyed the Christmas festivities, particularly the children's choir. Menus were discussed and some changes agreed, with a request for coffee cake more often agreed. The decorating programme for the home for 2016 was also discussed. Feedback from the recent residents' survey highlighted that some people didn't know how to raise a concern or complaint. The registered manager reminded people of the complaints process and about the suggestions box in the entrance hall.

Each person's room was personalised with things that were meaningful for them. For example, people were encouraged to bring family photographs, pictures and any favourite furniture or ornaments with them when they moved into the home. Each person was allocated one or two staff who acted as 'key workers' for the person. For example, staff supported the person to keep their room nice, helped with ensuring they had toiletries, looked after their clothes and labelled items for the laundry.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was in day to day charge of the running of the home. They were supported by a deputy manager, who they said was very good at systems and paperwork. The registered manager said the provider was also very involved in the business side of the running of the home. They met with them regularly and said they found them supportive. Staff said they felt well supported by the registered manager. When we asked staff what the best thing about the home was, their responses included, "Homely, and "Good team."

We received mixed feedback about the culture of the home. One relative said, "The care is respectful, courteous and there is a warm culture within the home." However, two relatives had said they weren't entirely satisfied with how their concerns were responded to. Following the inspection, a professional who provides a service to the home contacted CQC to raise a concern with us. This related to an attitudinal concern as well as feedback from staff about needing to consult the on call staff member, out of hours, before contacting a doctor when a person became unwell. The professional was concerned this system might cause undue delays. We asked the provider to investigate and respond to us about these concerns. We received a full response, which showed they had reviewed the out of hours arrangements, and were satisfied they provided support for staff and did not cause unnecessary delays, but would continue to monitor closely. They also confirmed they were addressing the attitudinal concern.

The service had a range of policies and procedures which were kept in the registered manager's office, so were not easily accessible to staff. These were quite old, dated 2012 and didn't include the most up to date references to national guidance and legislation. Some key policies were not included, for example, there was no Mental Capacity Act policy and procedures.

The provider had a range of quality monitoring systems in place which were used to monitor the quality of the service. However, these were not fully effective because they did not identify the breaches of regulations we found at this inspection. For example, there was no regular health and safety checks of the environment of the home documented. This meant some environmental risks, which were putting people at increased risk, had not been recognised or dealt with. The registered manager said they read through people's records once a fortnight to monitor the standard of record keeping. However, these checks were not documented and had not highlighted the lack of individualised information.

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

Accidents and incidents were monitored for themes and trends, so appropriate action could be taken in response. For example, further assessment and advice from external professionals was sought for a person who was having regular falls.

Records of monitoring in the kitchen using the 'Safer Food, Better Business' system demonstrated that staff followed recommended food safety management procedures and food hygiene regulations. Food

preparation facilities are given a rating from 0 to 5, 0 being the worst and 5 being the best. The most recent environmental health visit had given the home a rating of 4.

A communication book was used to communicate messages between staff and remind staff about people's appointments and about care plan amendments. A night report book was used to document any significant issues overnight to staff coming on duty. This also showed staff duties carried out by night staff which included security checks of the home, doing laundry, ironing and some cleaning. A diary entry showed the registered manager had met with district nursing staff to discuss several people's health needs.

People and relatives views were sought regularly through surveys, and there was evidence of actions taken in response. For example, menu changes were made in response to a food survey done in April 2015. The provider conducted an annual satisfaction survey, and the responses received showed people and relatives were satisfied with the care. Where they made suggestions about improvements to the environment, these were underway. A comments box was also used to seek feedback, although the registered manager said this wasn't well used. However, it wasn't located in a very obvious place, and there was no paper/pens available to encourage people/families to use it.

The registered manager said team meetings were held every two to three months, with a separate night staff meeting every six months. For example, at the most recent team meeting the registered manager discussed the care needs of a person attending for day care. They reminded staff about the importance of people having regular nail care, following feedback from a relative about this.

An annual staff survey was completed. The 2015 survey showed most staff thought the team worked well together. There were a few comments about poor attendance at team meetings, although the registered manager said staff had to sign to say they had read the minutes of the meeting, if they could not attend in person.

The manager kept up to date with regulatory changes through the CQC website and submitted notifications regularly as required by the regulations.

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 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 9 HSCA RA Regulations 2014 Person-centred care Some aspects of people's care was not person centred, and did not reflect their individual needs or preferences. This is a breach of Regulation 9 (1) (a), (b), (c), 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use services, who lacked capacity, did not have their legal rights fully protected because staff were not acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005. This is a breach of regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected some environmental and safety risks had not been adequately assessed and managed. This is a breach of regulation 12 (1), (2) (a), (b) and (d).

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 Some people were subject to restrictions on their liberty for their safety and well-being, without the proper processes in place. This is a breach of regulation 13 (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to adequately assess, and monitor the quality and safety of the services provided. They failed to identify and take and take action in a timely way to improve systems and mitigate risks to the health, safety and welfare of people. This is a breach of regulation 17 (1) (2) (a) (b).