Crabtree Care Homes

The Raikes Residential 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 9 May 2016 and was unannounced.

We last inspected this service in March 2014 and found it was meeting all of the regulations inspected at that time.

The Raikes Residential Home is registered to provide residential care for up to 31 people. Most of the people who use the service are older people, some of whom live with dementia. On the day of our inspection 31 people lived at the home. The home is situated just outside the village of Silsden. Accommodation is provided in single rooms on the ground and first floors. Two passenger lifts provide access to the first floor.

At the time of this inspection the manager was not registered with the Commission. However, following our inspection they submitted an application to become the 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 we spoke with told us they felt safe and did not raise any concerns about the way they were treated. Staff were aware of action they would take to keep people safe such as in the event of an emergency or if they were concerned someone was at risk of abuse. We found safeguarding concerns were being referred to the local safeguarding team but the Commission was not always being notified about them.

We found some care records were not complete and did not always demonstrate that risk had been mitigated. The manager was in the process of updating all care records to ensure they were sufficiently detailed and contained person centred information.

Overall risks to people's health, safety and welfare were identified and action taken to manage the risk. However, care records did not always fully reflect the risk reduction strategies staff followed.

Our observations, discussions with people and review of records led us to conclude there were sufficient staff to meet people's needs.

Overall we concluded there were processes in place to make sure people's medicines were managed safely. However, some improvements were needed to ensure a consistent approach. We recommend the provider reviews and revises their protocols for 'as required' medicines to ensure they are developed in line with current guidance and provide clear guidance for when people should be provided with these medicines.

We concluded the manager was taking appropriate action to implement an effective system of staff training but there was still work to be done in this area.

We found the premises to be clean, tidy, appropriately furnished and homely. Some window restrictors needed to be replaced to ensure they met current guidance. Following our inspection the manager arranged for this work to be completed.

People told us the food was good and our observations showed people received sufficient food and drinks. However, care records did not always evidence nutritional risk had been effectively managed, especially in relation to people's fluid intake.

People provided positive feedback about the standard of care provided and told us staff were kind and caring. We saw staff knew people well and used this knowledge to provide care which met people's individual needs. Staff treated people with respect and dignity and offered support in a kind and sensitive way.

Staff supported people to see other health care professionals so they could maintain good health and we saw examples where staff had made referrals where they were concerned about someone's health and wellbeing. The advice provided by health care professionals was not always reflected within care records.

Assessments and applications had been made to ensure the rights of people with limited mental capacity were protected in line with the legal framework of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005. Staff had a good understanding of their responsibilities in protecting the rights of the people they cared for.

Staff encouraged people to make decisions about how they wanted their day to day care to be delivered. We saw staff took time to explain things to people and offered choices so people were able to make informed decisions.

The feedback we received from people who used the service and their relatives indicated the activities programme needed further improvement. The manager and provider were in the process of addressing this but we concluded further improvements were still required.

Since coming to post the manager had started to implement additional opportunities for involvement such as structured care reviews and resident meetings. Relatives particularly welcomed these changes as they said the service had not always been good at keeping families informed and involved in the past.

The manager had developed an improvement plan which identified the areas where they needed to focus on implementing change. They had also implemented systems to audit the quality and safety of the services provided and identify for themselves others areas where improvements were needed. We saw examples where these checks had been effective in identifying and addressing areas for improvement.

However, it was too early to test the long term effectiveness of these audits. We were also unable to see evidence there had been robust quality assurance systems in place prior to the new manager coming to post. Some areas for improvement were identified by the Commission, rather than being identified through the service's own quality assurance processes.

The feedback about the new manager was positive and we saw they promoted an open and honest culture. We concluded that the provider, manager and staff team were committed to making the required improvements, helping to positively change the culture of the organisation and to ensuring people received good quality care.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

The service was not always safe.

Risks to people's health, safety and welfare were identified and managed. However care records did not always have complete details of risk reduction strategies.

Overall we concluded people's medicines were managed safely. However, some improvements were needed to ensure a consistent approach.

People told us they felt safe. Staff understood safeguarding procedures and how they should report any suspicions of abuse.

Staff were recruited safely and there were enough to meet people's needs.

Some window restrictors needed to be replaced to ensure they met current guidance and clearer strategies were required where people could not access their call bell.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us the food was good and we saw people received appropriate support to eat and drink. However, care records were not always complete and did not fully evidence nutritional risk was being managed.

Staff supported people to see healthcare professionals to help maintain good health. However, their advice was not always translated into clear care plans.

Staff told us they received the training they needed to work safely and meet people's needs.

Staff had a good understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 and their role in protecting the rights of people with limited mental capacity.

Is the service caring?

Good

The service was caring.

People provided positive feedback about the standard of care provided and told us staff were kind and caring.

Staff knew people well, treated people with respect and dignity and offered support in a kind and sensitive way.

Staff took time to explain things to people, offered choices and encouraged people to make decisions about how their day to day care was delivered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and staff knew how people liked their care to be delivered. The manager was in the process of improving care plans to support the consistent delivery of person centred care.

The feedback we received indicated that the activities programme needed further improvement.

The manager had begun to implement additional opportunities for involvement.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home did not have a registered manager.

New quality assurance systems had been implemented which had begun to identify and address areas for improvement. It was too early to test the long term effectiveness of these processes.

Some areas for improvement were identified by the Commission, rather than through the service's own quality assurance processes.

Feedback about the manager and provider was positive. We concluded they were committed to improving the quality of care provided.

The Raikes Residential 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 9 May 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert-by-experience had experience of services for older people and people who lived with dementia.

Before the inspection, we reviewed the information we held about the provider such as notifications and any information people had shared with us. We also spoke with the local authority commissioning and safeguarding teams to ask them for their views on the service and whether they had any concerns. We reviewed the information on the Provider Information Return (PIR). This 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.

During the inspection we spoke with eleven people who lived at the home, four relatives, three care workers, the cook, the administrator, the manager, the provider and a visiting healthcare professional. We looked at five people's care records, medication records and other records relating to the management of the home such as duty rotas, staff files, training records, maintenance records and service reports, surveys, audits and meeting notes.

We observed people being cared for and supported in the communal areas and observed the meal service

at breakfast and lunch. We looked around the home at a selection of bedrooms, bathrooms, toilets and the communal rooms.

Requires Improvement

Is the service safe?

Our findings

We found risks to people's health, safety and welfare were identified and action was taken to manage the risk. For example, in one person's records we saw they were at risk of sliding out of their chair and a one way slide sheet was being used to reduce this risk. In other cases we saw people who had been identified as being at risk of falling had motion sensors in their rooms to alert staff when they were moving during the night. This enabled staff to go to their assistance quickly which helped to reduce the risk of further falls. The manager analysed all incidents and accidents and provided examples to show they had identified trends and patterns and taken action to reduce risks. In one case we saw care records did not fully reflect all of the risk reduction strategies which staff adopted to reduce the risk of falls. However, the staff we spoke with were aware of the actions to take and the manager showed us they were in the process of updating this person's care records. Staff and this person's relative told us the risk reduction strategies had been successful in significantly reducing the number of falls for this person.

People we spoke with told us they felt safe and did not raise any concerns about the way they were treated. The staff we spoke with told us they had received training on safeguarding. They understood the different ways in which people could be subjected to abuse and knew how to report any concerns. They were able to tell us who they would report any concerns to, both inside the organisation and, if necessary, to external agencies such as social services, the police or the Commission. They also told us that the manager and registered provider had an open approach and they had confidence any concerns they raised would be dealt with appropriately. This showed us staff were aware of the systems in place to protect people from the risk of abuse. These safety measures meant the likelihood of abuse occurring or going unnoticed were reduced.

We looked at the safeguarding file and saw two incidents had occurred in the past six months. Both had been reported to the local authority and the manager had taken action to reduce the risk of repeated incidents. One of the incidents which occurred two weeks prior to our inspection should have been reported to the Commission but had not been. The manager said this was an error and assured us it would not happen again. They submitted a retrospective notification to the Commission. Following our inspection we wrote to the registered provider and the manager to highlight their responsibilities to notify the Commission of certain incidents which occurred in the home. We outlined what action the Commission may take if we found evidence they had failed to notify us of incidents in the future.

The manager told us the usual staffing levels were one senior care worker and four care workers during the morning, (8am to 3pm) and one senior and three care workers from 3pm until 10pm. Overnight there were two staff on duty, one of whom was a senior care worker. The manager usually worked Monday to Friday and was not included in the staff numbers. In addition to care workers the home employed separate staff for housekeeping, catering, maintenance and administration. There was also an activities organiser who worked 16 hours; this was usually in the afternoon, four days a week. Our observations, discussions with people and review of records led us to conclude there were sufficient staff to meet people's needs.

The manager told us they had recently recruited new staff and had no staff vacancies. We looked at the files

of three newly recruited staff members. The records showed all the required checks had been completed before the new staff had started work. This included two written references and a criminal record check with the Disclosure and Barring Service. We saw evidence any gaps in employment had been explored. This helped to make sure people were protected from the risk of being cared for by staff who were unsuitable to work in a care setting. The administrator told us they and the manager had made some changes to improve the way staff recruitment was done. For example they had implemented more detailed application forms and interview record forms.

We found the home to be homely and appropriately furnished. The provider had an ongoing programme of decoration and refurbishment to ensure the building was well maintained. They were in the process of creating a sun room which would provide an additional communal room and the manager explained they were in the process of getting quotes to undertake work on the front patio area to create additional secure outside space. Since coming to post the manager had introduced a range of infection control checks such as checks of mattresses and curtain cleaning. We found the home to be clean, tidy and odour free.

The bedrooms we saw were personalised and many offered views over the Aire valley. Most bedrooms had call bells positioned by the bed so they could be easily accessed in the event of an emergency during the night. The people we spoke with told us staff were usually "Very prompt" to come if they pressed their call bell. However, we saw in two bedrooms the call bells were not easily accessible. For example, in one bedroom the call bell was positioned behind a chest of drawers. The manager explained that the people who lived in both rooms did not have the capacity to use their call bell and alternative arrangements were in place to check these people were safe, such as hourly checks during the night and the use of motion sensors. However, it was not clear from these people's care records that they were unable to use their call bell and that these safety measures were in place. The manager explained they were in the process of completing best interest meetings for people who were unable to access their call bells so that a clear and person centred strategy could be developed and included within each person's care records.

Restrictors were in place on the upstairs corridor and bedroom windows we looked at. However, some were not sufficiently robust to withstand damage and could be easily removed. This meant they did not comply with the Health and Safety Executive's guidance published in June 2014 called 'Health and safety in care homes'. The manager arranged for the maintenance staff to check all window restrictors and ensure any which did not comply with current guidance were replaced. Following our inspection the manager confirmed that this work had been completed.

CCTV was in operation in communal areas and corridors. There was signage alerting people that it was in use on the front door and in other communal areas and the manager explained that this was explained and discussed with people before they moved into the home. Checks on safety related systems such as water, gas and electric took place to help keep the building safe.

Overall we concluded people's medicines were managed safely. However, some improvements were needed to ensure a consistent approach. For example, some medicines are prescribed with special instructions about how they should be taken in relation to food. We saw systems were in place to ensure some medicines, such as Alendronic Acid, were given in line with the prescriber's instructions. However, the system in place for the medicine Lansoprazole needed to be refined to ensure the prescriber's instructions were followed. This was discussed with the manager who said they would speak to the supplying pharmacist to make sure medicines such as Lansoprazole were dispensed in a separate container to help reduce the risk of them being given too close to meal times.

We observed a care worker giving a person their medicines. We saw they were kind, caring and took their

time. They sat down beside the person and asked, "Am I all right to give you your medicines now?" They then explained what the medicines were for and stayed with the person until they had taken them. They then repeated this for everyone who received medicines.

We found medicines were stored securely although the storage cupboard used for medicines classified as controlled drugs was not compliant with current legislation. The manager told us they had already identified this. They showed us they were in the process of creating a new medicines storage area which would include a proper controlled drugs cabinet. Medicines which required refrigeration were stored correctly.

When people were prescribed dietary supplements this was recorded on their medication administration records (MAR). Senior care staff who administered medicines were also responsible for giving people their dietary supplements and recording this on the MAR. There was a similar system in place for topical medicines such as cream and lotions.

Some people were prescribed paracetamol to be given on an 'as required' basis. We found there were not robust person centred protocols in place to ensure these medicines were given consistently and appropriately. The records we saw did not show people had been given these medicines in an inappropriate way, however the manager told us this would be addressed to reduce this potential risk. We recommend the provider reviews and revises their protocols for 'as required' medicines to ensure they are developed in line with current guidance and provide clear guidance for when people should be provided with these medicines.

The manger told us none of the people living at the home at the time of our inspection received their medicines in a disguised format referred to a covert medication. They said people's right to refuse their medicine was respected and if people continued to refuse a prescribed medicine they would inform the person's GP and ask for their medicines to be reviewed.

The manager told us all the staff involved in giving people their medicines had received training and refresher training updates had been arranged. The manager told us competency assessments for staff involved in the administration of medicines were done once a year and/or following any issues identified by medicines audits.

Requires Improvement

Is the service effective?

Our findings

People told us they enjoyed the food served at the home and there was plenty of choice available. One person said, "The food is very good." At lunch time we heard another person say, "The lunch is very nice, I am sorry I can't do it justice."

We saw people were involved in making decisions about their meals and were offered choices of food and drink. During the morning of our inspection we observed the cook sitting with a person who lived at the home talking about the choice of meals available for lunch which were steak pie or cheese salad. The person wasn't sure which to choose and after a few minutes said they would try the cheese salad. The cook responded by telling the person to just say if they changed their mind because they could always have something else.

We observed lunch and saw this was a relaxed but well organised occasion which was managed at the pace of the people who lived at the home. The meals provided had been chosen earlier and people were reminded of what was on offer. Alternative food options were provided to people who no longer wanted their original choice. People were respectfully left to manage their own meals and optimise their independence. However where required staff provided people with individual assistance. The food was well presented and looked appetising and people appeared to enjoy it.

We spoke with the cook. They knew about people's individual likes and dislikes and told us they regularly talked to people to find out if they would like different things on the menus. They were able to tell us about people who needed their food fortified and said they did this by adding butter, cheese and cream to various dishes and by using full fat milk. The cook also knew when people had dietary supplements prescribed although the senior care staff were responsible for making sure people received their supplements. The cook told us the only special diets they were catering for at the time of the inspection were diabetic diets, however, they were aware of where they could get information about other diets such as Halal or gluten free should the need arise. The cook said they felt they were part of the team and were kept informed about any changes in people's needs.

We saw people's nutritional needs were assessed and people's weights were monitored. In one person's records we saw they had lost over 8kg of weight between December 2015 and March 2016. In April 2016 they had started to gain weight again. The records showed since the appointment of the manager in February 2016 action had been taken to address the weight loss. However, the records were unclear about what actions had been taken prior to the manager coming to post. The person received a fortified diet and had been referred to their GP and prescribed dietary supplements. They had also been referred for a nursing needs assessment because of an increase in their overall care needs. There was information in the person's care records about the actions taken, however, details of advice given by professionals was not always reflected in care plans. For example, the GP had recommended a daily fluid intake of 1200 to 1500mls per day, but this had not been included in the person's eating and drinking care plan.

The persons food and fluid intake was being monitored by daily food and fluid charts. However, we found

they did not always provide a full picture of the person's dietary intake. For example, mid-morning and afternoon snacks and supper were not always recorded and the dietary supplement, Complan, was sometimes recorded on the food charts or sometimes on the fluid chart. The fluid charts from 5 and 8 May 2016 showed a total daily fluid intake of between 360 and 750mls, all of which was short of the recommended 1200 to 1500mls.

In another person's records we saw they had lost over 6kg since December 2015. The cook told us the person had been unwell and had lost weight while in hospital. However, they added the person's appetite had now improved and said, "[Person's name] is doing well now." This was reflected in the care records which showed the person had gained 1.4kg between March and April 2016. We saw the person's GP had been consulted regarding their weight loss and general health.

The person's fluid intake was being monitored; however, a summary of the fluid charts between 2 and 8 May 2016 showed their average daily fluid intake was 688mls which is well below the recommended figure which suggests 1600mls as a minimum.

This meant some records were not complete and did not fully demonstrate that risks were being fully mitigated. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed people had access to a range of health and social care professionals such as GPs, advance nurse practitioners, district nurses, tissue viability nurse specialists, dentists, opticians and chiropodists. We saw assessments were carried out to determine if people were at risk of developing pressure sores. When people were at risk we saw the district nurses were consulted so that they could arrange for pressure relief equipment to be provided.

One relative told us they did not feel staff had been as proactive as they could have been when they told staff they had noticed a change in their relatives' health and behaviour which they felt may have been caused by an infection. However, other relatives and people who used the service did not raise concerns with us in this area and told us staff made prompt referrals if they had any concerns. We spoke with a health professional who visited the home to provide treatment. They told us they felt the standard of care was "Excellent" and people were always "Clean and comfortable" whenever they visited.

Since coming to post the manager had begun to provide staff with a more structured supervision and training programme. The administrator had completed a new training log which ensured staff training could be effectively monitored. As a result the manager had identified some areas where training refreshes were due. They had put plans in place to ensure staff received training in all key areas throughout the coming year. Training was a combination of class room based learning and distance learning where staff had to complete workbooks which were sent to an external company to be assessed. All staff were currently completing health and safety training workbooks and once completed would receive similar training updates in mental capacity, infection control and nutrition. Training in safeguarding, fire safety and first aid was also booked for June and July 2016. We concluded the manager was taking appropriate action to implement an effective system of staff training but there was still work to be done in this area.

The staff we spoke with demonstrated good knowledge about key topics which demonstrated the training they had received was effective. Staff told us they received the training they needed to work safely and meet people's needs. Staff told us they had received induction training when they started working at the home. They told us this included shadowing other staff until they got to know people and were competent to carry out their duties on their own. Staff told us they felt well supported by the new manager.

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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of the inspection there were three authorised DoLS in place and nine applications awaiting review by the supervisory body. We looked at the records for one person who had an authorised DoLS in place. The manager was still awaiting the paperwork from the supervisory body which detailed the conditions which had been imposed. We saw information within this person's care records to guide staff about what the DoLS meant to the person and the support staff provided. The staff we spoke with had an awareness of this and understood the implications for the day to day care they delivered. Staff also had a good understanding of the MCA and their responsibilities to protect the rights of the people they cared for. We saw other information within care records which provided staff with information and guidance such as mental capacity assessments. We saw where decisions had been taken in people's best interests these were not always clearly recorded. The new manager had already identified this and started to address it.

We saw people had signed consent forms in key areas such as the use of CCTV in the home. We also observed staff consistently asked people for consent before providing support, explained what they were doing and obtained the person's agreement before continuing. This showed staff made sure people were in agreement before any care was delivered.

Good

Is the service caring?

Our findings

We observed the atmosphere in the home was calm and relaxed. We saw staff had developed positive relationships with people and there were lots of good humoured exchanges, smiling and laughter between staff and people who used the service. Staff demonstrated a good knowledge of people and clearly knew how people preferred their support to be provided. We saw staff approached people with respect and support was offered in a sensitive way. For example, we saw one person became anxious whilst sat in the lounge. A care worker recognised this and brought them a cup of tea, sat down next to them and spent time providing them with reassurance and engaging them in conversation about topics which they knew were of interest to them. We saw this person's anxiety quickly reduced and they began smiling and joking with staff.

Overall people provided positive feedback about the standard of care provided. One person told us, "I love it here" whilst another person told us "I get everything I need here." People told us staff were kind, caring and provided good support and they felt well cared for by staff. One person told us, "The staff are really good and helpful."

The feedback from relatives about the standard of care was generally positive. They told us they could visit whenever they wanted and were always welcomed. One relative described how much more settled, safe and happy their relative had been since they moved into the home and felt this was due to the care staff had provided. One relative told us, "[My relative's] hair isn't always brushed if I come first thing and there have been times when [their] teeth haven't been cleaned." They felt this was because some newer staff did not always have attention to detail. However, another relative told us they were "impressed" with how well "turned out" their relative was whenever they visited. Our observations were that staff had taken time to support people with their personal care. People's hair was combed, their nails were clean and men had been supported to shave. People were dressed in clean clothing and wore appropriate footwear. One person told us, "I like to dress nice, staff make sure I still can, they help me to keep clean and tidy."

We saw staff took time to explain things to people and offered choices such as where people would like to sit and what they would like to eat and drink. We saw staff asked permission from people before providing support. For example, before serving breakfast we heard a care worker say to a person who lived at the home "Can I pop this pinny on to keep your nice blouse free from cornflakes." They then waited for the person to give a response before proceeding. This showed us staff encouraged people to make decisions about how they wanted their day to day care to be delivered and ensured they were provided with enough information to make an informed decision.

We saw examples of care being delivered in line with people's individual preferences and care plan. For example, one person's care records detailed they preferred to go to bed at 10pm and our review of their daily notes showed this was happening.

We observed staff were mindful of ensuring people's dignity was maintained. For example, we saw one person needed support with their personal care whilst they were sat in the communal lounge; staff ensured this person received the support they needed in a discreet and sensitive way to ensure people sat close by

were not aware of this. The manager explained they planned to introduce 'Dignity Champions' to help mentor new staff and share best practice.

Our review of care records showed end of life care plans were in place which included information about where people would prefer to be cared for at the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and care plans were in place to show how people should be supported to ensure they received safe and effective care which met their individual needs.

We saw that care plans and risk assessments were up to date and reviewed monthly by staff. The care records we reviewed did not have evidence of care reviews with people and/or their relatives. We also saw limited information about people's personal preferences such as their likes, dislikes, hobbies, interests and social histories. Our observations led us to conclude staff knew people well and used this knowledge to provide people with personalised care. However, the manager explained these were areas they had identified for improvement since coming to post. They had started to make improvements through introducing a key worker system. Each key worker had been matched to a person who lived at the home and acted as a key point of contact for the person and their relatives. Their first responsibility as a key worker had been to complete an individual preference plan with the person and/or their relative. The manager explained this enabled the key worker to help build a rapport with the person and get to know and understand them as an individual. We looked at some of the completed personal preference plans and saw these were detailed and provided useful information such as what foods the person enjoyed.

Key workers were being trained in how to complete an effective care review by the manager. Once they had completed a personal preference plan and this had been checked and signed off by the manager the key worker was then responsible for completing a care review with the person and/or their relatives. The manager explained these would be at least once a year but would be more often if people's needs changed or if the person requested a review. The first full care reviews under the new system were due to take place at the beginning of June 2016. As this was a new system we were unable to assess its effectiveness as part of this inspection.

We found that the level of detail in care records varied. For example, one person's care plan about communication stated staff should pose questions which could be answered by 'yes' or 'no'. This was useful information which showed staff how to support the person to avoid confusion and make the most of their limited verbal communication. In another person's care plan we saw specific information about how often staff should support them to change their position in order to reduce the risk of developing skin damage or pressure sores. However, other care plans we looked at did not have the same level of detail. For example, one person's care plan about medication did not have any information about a medicine which should be taken 30 to 60 minutes before food or about a prescribed dietary supplement. The manager told us they had already identified this and were in the process of reviewing and updating all care records. We checked some care records they had reviewed and saw they contained more specific and detailed information.

Information about how to make a complaint was available to people in the entrance to the home. The manager explained that no formal complaints had been made since they came to post in February 2016 and there were no records of formal complaints being made in the past 12 months. The manager was able to describe the approach they would take if any complaints were made in the future which included analysis of themes so any trends could be identified and addressed.

Overall people were satisfied with the care provided. One person told us, "I have no complaints, I go to bed when I want and get up when I want, no one tells you what to do." The feedback we received indicated that the activities programme needed further improvement. Most people and relatives we spoke with told us they felt there could be more stimulation and meaningful occupation. Many people told us they were often "bored." One person who used the service told us, "There's too little to do, nothing to motivate us, a lack of activities and people just go to sleep. We used to go out on the minibus and had nice little trips." Another person told us, "There's not much to do during the day" and another person told us, "There are no trips and I like to get out." One relative told us, "People just fall asleep. I would like staff to spend 5 or 10 minutes individually with [my relative]. They need someone with some get up and go and ideas on activities, not just talking." Another relative told us, "There was only one trip for all of last year and nothing [planned] this year." People told us they really enjoyed the DVD cinema showings on a Sunday afternoon, but felt other than that the activities on the weekly schedule did not relate to their own experience.

During our inspection we saw staff played inflatable games with people, however a relative told us this was because they had initiated it. We also saw the provider engaged people in singing songs. People told us they had really enjoyed this but many commented it was a "one off." The manager and provider told us they were trying to improve the activities on offer. A new activities coordinator had been employed and worked four days a week. The manager told us they had ordered new materials for activities and had discussed ideas for group based activities with staff as part of a recent team meeting. They also said they were due to arrange some trips out using the provider's minibus during the coming months. Our review of the resident's meeting minutes for April and May 2016 confirmed this. The minutes also showed people were consulted about what activities they would like in the future and were being involved in arranging a celebration for the Queen's 90th birthday in June.

One relative told us that whilst staff were friendly, they felt there was not always continuity between care shifts. They said sometimes when they asked staff questions their answer was that "They hadn't worked that shift." We saw handovers were completed at the end of each shift where key information and changes were discussed and the new key worker system was designed to provide relatives and people with a consistent point of contact.

The provider had recently sent out questionnaires to people who used the service and their relatives. The provider explained that these would be analysed by head office so that any trends and patterns could be identified. They said a plan would then be put in place to address any shortfalls. We checked a sample of completed questionnaires and saw the feedback was mostly positive. However, the main theme for improvement was around activities.

Since the manager had come to post they had begun to implement additional opportunities for involvement. This included a suggestions box so people could leave anonymous feedback, formal care reviews and regular resident and relatives meetings. They had also introduced a newsletter which was sent out to relatives and people who lived at the home. Relatives told us they had enjoyed reading about what was going on at the home and the positive changes which were being made. One relative told us, "I've just had my first newsletter and I really hope they do what they are saying." Relatives told us they were encouraged by these measures as in the past they felt there had not always been a lot of engagement with the families of people who live at the home.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager at the time of this inspection. A new manager had started in February 2016 and following our inspection they sent an application to become the registered manager to the Commission.

The manager explained that when they came to post they had completed a full audit of the service which included spot checks in all key areas such as medicines, environment, records, infection control, staff training and development. This then enabled them to develop an improvement plan which identified the areas where they needed to focus on implementing change. In addition, they had also implemented systems to audit the quality and safety of the services provided and identify for themselves others areas where improvements were needed.

We saw examples whereby these checks had identified areas for improvement and where they had put plans in place to address them. For example, the manager completed audits of care records and recognised all care records needed to be updated to include more detail and person centred information. They had also recognised that people and relatives needed to be more involved in the care planning process. As a result they had started to review and update all care records and had introduced personal preference plans and a formal care review process. We also saw their infection control audit had identified a number of areas for improvement which had been actioned, such as new light pull cords and more effective and accessible storage of personal protective equipment.

However, as these audits had only been in place for a short time it was too early to test their long term effectiveness. We were also unable to see evidence that there had been robust quality assurance systems in place prior to the new manager coming to post. There were also some areas which the Commission identified which had not been identified and addressed through a robust system of audit, such as the need to replace some window restrictors and the absence of consistent protocols for 'as required' medicines. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, we found the manager, with support from the administrator, had implemented more structured and organised systems and processes. All of the records we requested were readily available and a number of improvements had been implemented to make it easier for the manager to monitor and maintain oversight of the service. For example, visual logs of staff training, DoLS applications and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders, meant the manager could quickly establish the current position and ensure any impending deadlines or expiring dates were highlighted and actioned appropriately.

People who used the service, relatives and staff all provided positive feedback about the attitude and approach of the new manager. They were all encouraged by the improvements that had occurred so far and were looking forward to the future changes which were also planned.

Staff told us the provider and management was supportive and listened to them. One described the new manager as being "very approachable" and said staff morale had improved following their appointment. Staff told us they had regular meetings to keep them informed of changes and many told us they would recommend the home to family or friends. One said, "It's a nice home really, they are well looked after".

The new manager was very open about areas that needed to be improved, it was evident they had made a number of positive changes since taking up their post. They were very enthusiastic and committed to improving the safety and quality of the services provided.

The manager told us the provider was supportive of the changes they had and were planning to make. The manager, staff and people who used the service told us the provider had a visible presence in the home and usually visited most weeks. We saw the provider logged most of their visits in a diary and summarised any key discussions they had with the manager. This meant we were able to see how they were actively monitoring the quality of care provided. We were particularly encouraged that the provider told us and we saw evidence that they had learnt lessons from the Commission's inspections of other locations and had used these experiences to plan and implement improvements at The Raikes.

We concluded that the provider, manager and staff team were committed to making the required improvements, helping to positively change the culture of the organisation and to ensuring people received good quality care.

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 17 HSCA RA Regulations 2014 Good governance Systems and processes were not fully established and operated effectively to ensure the service; Assessed, monitored and improved the quality and safety of the service provided. Assessed, monitored and mitigated risks relating to the health, safety and welfare of service users and others who may be at risk. Maintained accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided. Regulation 17 (1)(2)(a)(b)(c)