Barchester Healthcare Homes Limited

Langdales

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 4 and 6 November 2014 and was unannounced. This meant the staff and provider did not know we would be visiting. The service was last inspected in November 2013. They met the requirements of the regulations during that inspection.

Langdales is a detached building located in central Blackpool. The home was registered to accommodate up to 26 older people who required assistance with personal care. At the time of our visit there were 20 people who lived at the home. Accommodation was arranged around the ground and first floor with office accommodation on the second floor. There was a small garden area to the rear of the building. There was a passenger lift for ease of access and the home was wheelchair accessible.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager told us

Summary of findings

she was retiring soon after the inspection. Her successor had already been appointed and was due to take up her new post. She told us she would then apply to become registered with the Care Quality Commission.

The home was well maintained, clean and hygienic when we visited. However the lack of some hygiene practices left people with a poor level of personal cleanliness.

People we spoke with told us they felt safe and well cared for. However this did not always reflect the practice we saw. Staff had received safeguarding training but were not always able to transfer this knowledge into practice to protect people from the risk of poor care. Our findings on the inspection led us to raise three safeguarding alert with the local authority.

On the day of our visit we saw staffing levels were not sufficient or deployed appropriately to provide a good level of care and keep people safe. You can see what action we told the provider to take at the back of the full version of the report.

We looked at how medicines were prepared and administered. We saw medicines given to one person were not observed as being taken. We also found people's medicine were not always ordered in time. Failing to give people their medicines properly places the health and welfare of people at unnecessary risk. You can see what action we told the provider to take at the back of the full version of the report.

We saw the right care and support was not provided to some individuals around eating and drinking. This meant some people did not receive the correct nutritional intake. There were also limited interactions with more dependent people which left them unstimulated for long periods of time. You can see what action we told the provider to take at the back of the full version of the report.

Some areas of staff recruitment were thorough and effective but others were not robust and this lessened the protection from unsuitable staff working in the home.

We found people and where appropriate their relatives, were involved in decisions about their care. People had informative person centred care plans. These were regularly reviewed and updated. However not all staff were familiar with people's needs and wishes and some information was not recorded correctly.

People felt they had trusting relationships with staff and they respected their privacy and dignity. They said they could speak to staff in confidence and this would not be discussed with anyone who should not have the information. There was a range of ways for people to feed back their experience of the care they received. People were very positive about the way staff listened to them.

Staff spoken with said they worked well as a team and were supported by the registered manager and care manager.

The management team assessed and monitored the quality of the service. Although systems to monitor the health, safety and well-being of people showed areas where action was needed, this was not always carried out quickly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Although people told us they felt safe staff were not providing consistently safe and appropriate care to all people in the home.

Staffing levels were not always sufficient or staff appropriately deployed to provide safe care.

Medicines were poorly managed. Staff did not give medicines safely and people's medicines were not always ordered in good time.

Is the service effective?

Requires Improvement

The service was not effective

The food was well cooked and people were offered a choice of nutritious meals. The people we spoke with told us they enjoyed their meals. However more dependent people's nutritional needs were not met.

Appropriate referrals were made where people needed GP advice and treatment. However we saw other professionals were not always involved in their health care at the right time to keep people in good or the best of health.

Procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

Is the service caring?

Requires Improvement

The service was not always caring

We saw mixed experiences of care. We saw staff treating people with kindness and respect talking with people in a patient and caring way. We also saw some staff did not always provide care in a dignified way or treat people as individuals.

People were satisfied with the support and care they received and that staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were personalised and people and their families had been involved in developing these. Despite this, care was not always person centred. Sometimes what was written in the care plan was not carried out in practice. Also important information was not always recorded.

Summary of findings

There was a range of ways for people to make their views known. The registered manager listened to any minor irritations or grumbles. These were taken seriously and responded to.

There was an established programme of activities. We observed people participating in a range of activities during the day.

Is the service well-led?

Requires Improvement

The service was not always well-led

There were procedures in place to monitor the quality of the service. Regular audits were being completed but where senior managers had found issues these were not always dealt with quickly by the home.

People told us the management team and senior staff were approachable and willing to listen to people

Langdales

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.

This inspection took place on 4 and 6 November 2014 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who had experience of providing services for older people and people with dementia 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. The expert by experience for the inspection at Langdales had experience of services that supported older people and people with dementia.

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We also checked to see if any information concerning the care and welfare of people living at the home had been received.

We spoke with a range of people about the service. They included the registered manager, members of staff on duty, twelve people who lived at the home, relatives and health care professionals. We also spoke to the commissioning department at the local authority and contacted Healthwatch Blackpool prior to our inspection. Healthwatch Blackpool is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced whilst living at the home

Before the inspection the registered manager completed a 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 our inspection we spent time observing the care and support being delivered throughout the communal areas of the home. This included a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of six people, the medicine records of nine people, the previous four weeks of staff rota's, recruitment records for four staff, the training matrix for all staff, and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

We looked at how Langdales was being staffed. We did this to make sure there were enough staff on duty to support people throughout the day and night. We found there was not always enough staff on shift, or they were not deployed in the most effective way. At mealtimes people were not assisted with their meals as they needed. People were left unsupported when they did not have the ability to ensure they had adequate nutrition. In the evening there were three staff on duty. None were available to assist one person who needed help with their meal. After the evening meals, one member of staff was involved in clearing the meal away and another giving medication, leaving only one member of staff to support people.

It was also evident from our observations where two people who had high care needs, they were left sitting unattended, with little stimulation or attention. We saw one person was highly dependent on staff who was receiving little attention. The registered manager told us that they were awaiting a nursing place in a chosen home for people with dementia. When we inspected there were not sufficient staff to support the person safely and appropriately. Staffing levels were not sufficient or were not deployed appropriately to provide a good level of care and keep people safe. This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the registered manager if she regularly reviewed staffing levels to make sure they met people's needs and dependency levels. She said she staffing in the home was set by senior staff in the organisation and needed to remain within those levels.

Staff told us they were well supported and worked well as a team. There was a low turnover of staff within the home and staff were familiar with the needs of individuals. This meant staff knew some of the support needed to care for people and were able to meet some of their needs.

The registered manager said she has recently recruited bank workers within the staff team to avoid using agency staff. This meant the staff would be more familiar with people's needs.

We did not hear anyone using their call bells during the inspection. However people said there were some occasional delays but usually staff responded quickly when they called for help. One person said about the staff, "They always respond if I do need to use my buzzer and they are brilliant."

People were not always protected from unsuitable staff working in the home. The application forms were not always fully completed including one person who had written that they had worked for the NHS with no further details. There were gaps and discrepancies in employment histories in two people's files which had not been followed up. This meant senior staff did not know what work the prospective member of staff had been doing during these periods.

The staff files we looked at showed us that a Disclosure and Barring Service (DBS) Checks had been received before new staff were allowed to work in the home. These checks were introduced to stop people who have been barred from working with vulnerable adults being able to work in such positions.

During the inspection we spoke with a member of staff who had recently been recruited. They felt the recruitment process had been fair and the appropriate checks had been carried out. They felt well supported by the manager and senior staff.

Medicines were not administered safely. We observed a small part of a lunch time medicines round and the tea time round being completed. During lunch we observed one person being administered their medicines. The member of staff placed the medicine pot on the table in front of the person then walked off. The person went to take the tablets out of the pot but dropped them onto their knees. They attempted to pick the tablets off their clothing but it was unclear if they found them all. The member of staff was not aware of this and did not know if the person had taken their medicines.

On the evening medicines round the member of staff left the medicine trolley open whenever they took medicines to people. On occasions they left the room leaving the trolley unattended. People were sitting close by and could have taken medicines from the trolley. Only towards the end of the medicine round, did the member of staff ask another member of staff to 'watch the trolley'. However they were busy at the other side of the dining area.

We also observed the member of staff 'potting up' two small pots of medicines. When we queried what the pots

Is the service safe?

were for, the member of staff said it was for two people to take when they had finished giving other people their medicines. They seemed unaware that this was poor practice. Or that they should not 'pot up medicines and leave them on the trolley while they administer medicines to other people.

People's medicines were not always ordered in good time. This meant people did not always have the medicines they needed. Two people had run out of medicines they usually took up to four times daily for relieving pain. Their individual medicines sheets show that they regularly took these each day. However these had stopped being given two or three weeks before the inspection. This meant they had received no pain relief for this period of time. We asked the member of staff administering medicines why these medicines were not being given. They told us the medicines had run out.

No effort had been made to reorder these medicines either before they ran out or immediately on finding they had run out. The member of staff acknowledged this was not good practice but could not answer why an urgent prescription had not been requested when It was first noted there was none left. We raised a safeguarding alert with the local authority about this.

The medicines records showed another person had not been receiving a prescribed daily food supplement. Staff said the person had been receiving them but the medicines record did not indicate this.

Although protocols for when necessary (PRN) medicines were in place for some people they were missing from other peoples notes. Staff did not follow instructions for administering medicines as written on the medicines record. This showed one person should be given some of their medicines before meals but staff said this was not given before meals as prescribed.

Night staff were not trained to administer medicines. This meant night medicines needed to be completed before the day staff left at 9pm, Teatime medicines were only given three to four hours before this. There was no evidence senior staff had checked if giving medicines at these intervals was safe and effective. Staff said if medicines needed to be given during night time they would have to contact the staff member who was 'on call'.

Staff told us that they worked to The National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes. NICE guidelines provide recommendations for good practice on the systems and processes for managing medicines in care homes. However it was clear from the practices seen that they did not. Failing to give people their medicines properly placed the health and welfare of people at unnecessary risk. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no unpleasant odours in any areas when we inspected the home. We saw that the home clean and fresh smelt throughout. Staff wore personal protective clothing when involved in personal care and at mealtimes. However the hot tap on the washbasin was not working in an upstairs toilet that staff used. This meant that staff could not wash their hands appropriately after using the bathroom and was an infection control risk.

When observing care before and after meals, we saw staff did not assist people to wash or wipe their hands or face or give them the opportunity to do so. This was of particular concern where some people were eating with their fingers and where they had wiped food around them.

Twenty people lived at Langdales when we inspected. There was a mix of abilities within the home. From discussions, there were six people who were relatively independent, and able to care for themselves with support of one member of staff when needed. Eleven people needed some help with personal care including some with moving and handling and three people needed full support.

People who lived at the home told us they felt safe at Langdales. One person said, "I am very happy here. I am much safer here than at home." Another person told us, "The staff are always willing to help us they are lovely. They look after us very well".

Staff we spoke with said they would have no hesitation in reporting abuse. They were able to describe the action they would take if they became aware of abuse. This showed us they had the necessary knowledge and information to understand about safeguarding people. However they had not seen that poor care at mealtimes, where a person with weight loss was not supported to eat was a safeguarding issue. Neither had they recognised that leaving people without appropriate pain relief was neglectful. This lack of understanding showed that staff were unable to transfer this knowledge into practice.

Inadequate

Is the service safe?

We looked at care records of two people who we were informed had behaviours that challenged the service. There was limited evidence in care records that assessment and risk management plans were in place. This meant staff were not equipped on how to manage such behaviours effectively.

Risk assessments were in place and, the provider made sure they were aware of any accidents or incidents to assist with keeping people safe

Requires Improvement

Is the service effective?

Our findings

Langdales is registered with the care quality commission (CQC) for supporting older people whose predominant needs are those relating to general ageing. When we inspected they were supporting a small number with moderate dementia. However the statement of purpose did not include details to demonstrate how the service would provide care to this client group. The home was not dementia friendly. The environment did not take into account the needs of people with dementia with decoration, signage and adaptations so it was difficult for people to orientate themselves around the home. There were no measures to improve well-being and independence for people with dementia, such as contrasting coloured equipment, crockery and furnishings. Staff had only received basic dementia awareness training which did not fully meet the needs of the people who use the service who have dementia.

We spoke with the cook who was knowledgeable about people's nutritional needs. We were shown how people chose their meals and how these were recorded. We were shown the choices available on the day's menu. However two different menus were shown to us or were in place for people to see, and none of them showed the meals available that day. This was confusing to people and meant the choices of some foods were not available.

We talked with staff about fortifying food and drinks to increase the calorific value. Some staff explained how they did this. Catering staff and some care staff were aware of people's preferences and dietary requirements including special diets. Others were only aware of a prescribed drink supplement that one person had and not of other ways to increase calorie intake for people who were underweight. The expert by experience and the specialist advisor ate with people at lunchtime. People were taken to the table up to 30 minutes before lunch was served, meaning they were waiting a long time. However people were then given plenty of time to eat their meal.

The food was well cooked and people were offered a choice of nutritious meals. In the dining room, there was some supervision, as staff took meals to people at their table. Interactions varied; in the dining room some staff were 'chatty' and talked with people as they served them. Others simply put the plate down in front of the person and walked away. We saw while most people ate in the dining room, two people with high care needs ate in the lounge. They received only brief and occasional supervision. One person was given her main meal when asleep. They were briefly woken by staff and prompted to eat but then they were left. The person tried to briefly eat with their fingers, then went back to sleep. Fifteen minutes later they were offered support to eat the meal, when the food was cold.

We were told the other person was eating little and had lost significant amounts of weight in the last year. The person was left unsupervised and struggling with their food at breakfast, lunch time and at the evening meal. At lunchtime we observed the individual for 50 minutes. The person was sat on a sofa and struggled to reach the food. Staff occasionally walked in the lounge and then out again. The person was unable to use the cutlery and crockery provided appropriately and resorted to eating with their fingers, wiping their hands on themselves and furnishings.

Staff came into the lounge twice, and asked the person if they were eating their meal, then left the room. When staff later went into the room and noted the person had not eaten, they removed the main meal and replaced it with a pudding. The staff member didn't cut up the pudding or assist the individual and left them struggling to eat the food. After 10 minutes the registered manager came in and assisted the person to eat their meal, which they ate.

The needs of these two people were not met during meal times. We raised a safeguarding alert with the local authority about this. The right care and support was not provided to these individuals around eating and drinking, which meant they did not receive the correct nutritional intake. This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Specialist dietary, mobility and equipment needs had been identified in care plans, where people had specific needs. However these plans were not always followed. We found fluid and food charts were inconsistently completed. A member of staff acknowledged that sometimes the last drink of the day could be 7pm. This meant as a minimum some people were going over twelve hours without a drink.

The people we spoke with told us they enjoyed their meals. People told us they always received as much as they wanted to eat. They said the meals were good. One person said, People told us the food was always very good. One person said, "I have put lots of weight on since I came in

Requires Improvement

Is the service effective?

here. The food is lovely and nothing is too much trouble. Another person told us , "We get to choose what we want to eat each day. There is always something I like." At teatime we saw that this was the case. One person refused the meal offered. They were offered several options and agreed on a tray of sandwiches with various choices available. Water coolers were available around the home. This meant people who were able to use them, could get cold drinks when they wanted.

We saw people's care plans contained clear information and guidance for staff on how best to monitor people's health. People told us staff organised for the GP to visit if they were unwell. Appropriate referrals were made where people needed GP advice and treatment. However we saw that more specialist referrals such as to the dietician were not always requested as needed. One person needed specialist support from a dietician to support them with receiving adequate nutrition. However this referral had not been made.

Staff did not always takes preventative action at the right time to keep people in good or the best of health. We saw one person was holding their mouth as though in pain. We asked staff about this. The member of staff said that the person was not in pain; but often held their face like that. She said that the person had lost a lot of weight recently and their teeth did not fit them. There was no record that a dental appointment had been arranged for them. This may have explained their reluctance to eat.

We spoke with the staff and checked the training records for all staff employed by the home. This confirmed staff had access to a company wide induction programme, and mandatory training. This included health and safety, moving and handling, food hygiene, safeguarding and for senior care staff, medication administration. Many staff had also completed national training in care. Staff told us they were well supported by the registered manager and the organisation in terms of training and attending courses. This meant they were able to develop their skills and knowledge. Minutes of supervision file showed supervisions took place bi-monthly. However records showed these were limited, covering only personal development.

The home had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with the registered manager and staff to check their understanding of MCA and DoLS. They understood their responsibilities in relation to these areas. The registered manager discussed situations where the home would look at the best interests of people. Where people did not have the capacity to make decisions, where appropriate, their friends and family and professionals were involved.

Senior staff demonstrated understanding of the MCA code of practice and confirmed they had received training in these areas. This meant they made appropriate arrangements where there were concerns about a person's ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

Relevant staff had been trained to understand when an application should be made. The registered manager showed us copies of DoLS applications they had recently made. This included an urgent application for authorisation in relation to a recent issue and applications for most people in the home in relation to the Cheshire West judicial review. The judicial review was where the Supreme Court stated the conditions where a DoLS application was needed. This ruling resulted in a rise of DoLS applications and was the reason for the high number of applications made by the provider.

We spoke with the some professionals involved in reducing hospital admissions from care homes. They told us they found the home staff really helpful. They found the staff were informative and knowledgeable. Adding they were cooperative and willing to share knowledge. We had responses from external agencies including the social services contracts and commissioning team. They told us they were satisfied with the care provided and had no concerns about the home. This information in addition to discussions in the home, helped us to gain a balanced overview of what people experienced living at Langdales.

Requires Improvement

Is the service caring?

Our findings

We saw staff did not always provide care in a dignified way. We saw staff did not assist people to wash or wipe their hands before or after lunch, despite two people eating with their fingers. Also one person did not have their clothing, changed although they had spilt on it at lunch time.

People were not always at the centre of the care they received because staff sometimes focussed on the task, rather than them, as individuals. We observed one member of staff moving an individual in their wheelchair without using footrests and then assisted them out of the chair without putting on the brakes. This made the wheel chair move in an uncontrolled way as they rose from it. Staff then quickly put the brake on.

We saw some good moving and handling situations where the members of staff explained what they were going to do and then carried out safe transfers. However this approach was inconsistent as sometimes staff did not explain things to people or take the time to make sure they knew what was happening. We saw two staff moving a person without explaining what they were doing until the person called out, asking what was happening to them. The poor care practices were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at care records and other associated documentation. We saw evidence that people who lived at the home, and/or their family members had clearly been involved with providing an informative life history. The care records were laid out in such a way that it was easy to locate information. However although the care plans were in place, daily records on individuals were not always completed or had very limited information about significant events. This meant staff did not have the knowledge they needed to provide person centred care for people.

Person centred care aims to see the person as an individual. Instead of treating the person as a collection of illnesses and behaviours, person-centred care considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs. Person-centred care also means treating residents with dignity and respect. It makes the rules and procedures fit the individual rather than the individual fitting the rules and procedures.

During our visit we spoke with people who lived at the home and their relatives. We also spent time in all communal areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. Although the inspection found some good care we also found areas of concern. Although staff were caring they did not always treat people as individuals. We saw most staff were task focused and were busy doing 'jobs' rather than interacting with people. Some staff interacted with people as they were carrying out care tasks. However we did not see staff sitting and talking to people for any meaningful period of time as they were very task focussed.

People were satisfied with the support and care they received and they were happy at the home. One person said, "I was in another Blackpool home for two years but coming here was the best move I made, it's like home from home." A relative told us of the improvement since their family member moved into the home. They said, "The difference is wonderful, the staff are amazing. They spend time with clients and make sure all is well." Although we valued the comments from people and their relatives our experiences of the care were not always as positive as their views.

People felt they had trusting relationships with staff and that they respected their privacy and dignity. They said they could speak to staff in confidence and this would not be discussed with anyone who should not have the information. We saw staff treating people with kindness and respect talking with people in a patient and caring way. One person told us "There is a good standard here from the staff to the food and they care for us well." Another person said, "This is a good place and they do everything they can to look after us."

Requires Improvement

Is the service responsive?

Our findings

We spoke with the registered manager about how they developed care plans when people were admitted to the home. Senior staff told us care plans and risk assessments were completed soon after admission. We saw this ensured they had as much information as possible so they could provide the right care and support for people. However one person had conflicting information regarding end of life and resuscitation. This meant no-one would know whether to resuscitate the person or not if this situation arose.

There were mixed experiences of how information about people's likes and dislikes were taken into account. Some staff clearly checked this information. One member of staff told us of her efforts to find a specialist craft person to assist an individual to continue with their particular craft interests. Another member of staff told one person they had not included a particular vegetable on their meal as they knew they didn't like it. However other staff were unable to discuss basic information about individual's likes or needs

Staff dealt with an emergency situation appropriately, shortly before the inspection began. They contacted the emergency services for assistance and guidance. However they did not record in the person's care records that the person had fallen, needed medical attention or the advice given by the paramedics. This meant staff looking after the person later that day were unaware of the accident. Therefore they did not know the extra vigilance needed to care for the individual to provide effective aftercare.

We also saw good care practice. We saw how a member of staff used care information about one person. They were giving the person a pudding when they realised it may have an ingredient in that the person was allergic to. They quickly explained to the person what they were doing and took it back to the kitchen to check, returning with a safe alternative. The member of staff's vigilance averted a possible uncomfortable allergic reaction for the person.

There was a programme of activities in place organised by the administrator who also was involved in planning frequent activities and special events in the home. There were planned outings in the company minibus each week. The handyman was the driver for trips out. They were both enthusiastic about these. A trip was planned for during the inspection but was cancelled as the staff on duty had not completed appropriate first aid courses, so could not go. Several people told us how much they enjoyed the trips out. One person told us, "It is great fun when we get out on trips." Another person interjected "Maybe so but they are every blue moon."

Some staff were enthusiastic about activities and saw it as very much part of their caring role. Others were less so and one member of staff complained in front of people who lived in the home and visitors about having to go on an activity.

A 1940's duo of singers was entertaining people during our inspection. People were singing and joining in with the singers. One person said, "I enjoyed the singers earlier, they were lovely girls."

In the afternoon a quiz was organised to involve and stimulate people. However there were few activities aimed at people with dementia. several people who were unable to instigate contact or activities were sat for long periods of time with little to occupy them.

There was evidence there were organised parties and events throughout the year. During the inspection the lounges and dining areas were covered in union jacks, bunting and flags to remember remembrance Sunday. Two events had been planned for this occasion. Many people were wearing poppies some made by people in local homes. The staff team also decorated the home in 'themes'. We saw pictures of Halloween events. One person said, "There is always something on to entertain us and the staff are beautiful."

We looked at the care records of six people we chose following our discussions and observations during the day. People's care, treatment and support was set out in a written plan that described what staff needed to do to make sure personalised care is provided. Each person had an individual care plan which was underpinned with a series of risk assessments. Care plans were personalised and it was clear people's specific needs, choices and preferences had been discussed with them and their family members. Information was sought from a variety of sources during the assessment process including family members. Although the care plans were detailed and informative, daily records were scant and charts such as food and fluid charts were not always completed. This meant that relevant up to date information was not always in place so it was difficult to review care records accurately.

Requires Improvement

Is the service responsive?

The home had a complaints procedure which was made available to people they supported and their family members. We saw there hadn't been any recent complaints. The manager told us the staff team worked very closely with people and their families and any comments and minor issues were dealt with before they became a concern or complaint.

Concerns and complaints were taken seriously, explored thoroughly and responded to in good time. There had been no formal complaints received by the home. However the registered manager had an 'open door' policy and made time to listen to any minor irritations or grumbles. She felt that this meant concerns were dealt with at an early stage and did not become serious concerns.

None of the people we spoke felt the need to complain or raise any concerns. They told us they were aware of how to make a complaint and felt confident these would be listened to and acted upon. One person said, "I have been here a few years and have had no problems so far." Another person said, "They do their best for us here and I have nothing to complain about". People told us they had regular meetings with senior staff where they were able to discuss anything they liked and didn't like.

People were given information about the home and the organisation in the form of leaflets and booklets. This included information about the provider and home. The information was illustrated with photographs and set out in an easy read style. There was a wide range of information leaflets on display in the reception for people who lived at the home and their visitors.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The registered manager had been in place for a number of years and staff spoke very positively about their management and leadership of the home. We were told before the inspection the registered manager was retiring soon after the inspection. A new manager had been appointed from within the home. This meant this would reduce any disruption as she knew the people in the home, the staff and systems. She intended to apply to CQC to become the registered manager.

There were procedures in place to monitor the quality of the service. Regular audits were being completed by the registered manager and by senior managers from outside the home. Where senior managers had found issues these were not always dealt with quickly by the home. Audits included monitoring the homes environment, care plan records, financial records, medication procedures and maintenance of the building. Senior managers audited the home at least monthly and followed up on any issues in order to improve the service. It was clear senior managers had already highlighted some of the concerns CQC inspectors raised on this inspection. These included medication management and training and a lack of activities. Yet these had still not been rectified.

People told us the management team and senior staff were approachable and willing to listen to people. A relative told us, “It’s run smoothly with the emphasis on the well-being of those who live there.” The inspection did not always reflect this as we saw issues about safe and appropriate care and medicines management. People who lived at the home, their relatives and staff, told us they felt supported by the registered manager and they felt comfortable sharing any issues or concerns with them. They felt confident they would be listened to and action taken where necessary. Relatives we spoke with told us they were informed of any incidents or accidents and the registered manager worked in an open and transparent way.

Staff were supported by performance appraisal and supervision. This is where individual staff and those involved with their performance, typically line managers, discuss their performance and development and the support they need in their role. It is used to assess recent performance and focus on future objectives, opportunities and any resources needed. Staff meetings were also held to involve and consult staff. Staff told us they had meetings every six to eight weeks and they were able to give their opinions on any issues.

The registered manager told us the views of people who lived at the home were sought by a variety of methods. This was confirmed by talking with staff, relatives and people who lived at the home. There were a range of ways for people to feed back their experience of the care they received. This included surveys about the person’s experience of living in the home and monthly residents and families meetings. These gave people the opportunity to voice their opinions. The registered manager said senior managers analysed any suggestions or negative comments and acted upon them.

Systems were in place to assist the management team and staff to learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduced the risks to people and helped keep people safe.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person had not taken proper steps to ensure that each person received appropriate support to eat and drink sufficient amounts of food for their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the registered person did not have appropriate arrangements in place to manage medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken proper steps to ensure that, at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed and deployed for the purpose of carrying on the regulated activity.**