Prime Life Limited

Braunstone Firlands Nursing Home

Inspection report

Gooding Avenue
Braunstone
Leicestershire
LE3 1JS

Tel: 01162558809
Website: www.prime-life.co.uk

Date of inspection visit:
21 February 2017

Date of publication:
28 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 21 February 2017 and was unannounced.

Braunstone Firlands is registered to provide nursing and residential care and support for 24 older people with dementia and mental health needs. At the time of our inspection there were 22 people using the service.

Braunstone Firlands had a registered manager in post. 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.

Staff had a detailed knowledge of people's care needs, though some documents within the care plan contained repeated terms and incorrect names.

We found there continued to be insufficient staff numbers to provide any level of meaningful activities for people to engage their time. The registered manager had identified appropriate activities and pastimes, and had purchased some games and reminiscence cards to enable staff to commence these activities. There was no documentary evidence to suggest a planned activity programme was in place to regularly meet people's individual needs. There were enough staff to meet people's basic personal care needs.

Staff were aware of the reporting procedure for faults and repairs and had access to the company maintenance personnel to manage any emergency repairs, however environmental audits were not detailed enough to reveal issues that we became aware of at the inspection.

Staff were employed in accordance with the provider's recruitment procedures which ensured staff were suitable to work in the home. Staff received an appropriate induction and on-going training for their job role. Nursing staff were trained to administer medicines. Medicines were ordered, stored and administered safely.

Staff explained how they kept people safe from abuse, and knew what external assistance there was to report on suspected abuse. Staff were knowledgeable about their responsibilities and were trained to look after people and protect them from harm and abuse and were aware of whistleblowing. That ensured people were safe from abuse.

Staff had access to people's care records and were knowledgeable about people's needs that were important to them, which meant the care offered by staff met people's assessed needs. Staff sought appropriate medical advice and support from health care professionals. Care plans included the changes to peoples care and treatment, and people were assisted to attend routine health checks.

Staff communicated with relevant professionals, to ensure people's dietary intake protected them from the

risk of losing weight. People's care and support needs had been assessed and people were involved in the development of their plan of care. People were provided with a choice of meals that met their dietary and cultural needs. Staff were aware of people's dietary needs.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Relatives we spoke with were also complimentary about the staff and the care offered to their relatives.

We observed staff speak with, and assist people in a kind, caring and compassionate way. We saw that people's dignity and privacy was respected which promoted their wellbeing.

Where appropriate people were involved in the review of their care plan, and when appropriate were happy for their relatives to be involved. We observed staff offered people everyday choices and respected their decisions. People were able to maintain contact with family and friends as visitors were welcome without.

Staff told us they had access to information about people's care and support needs and what was important to people. Care staff were supported and trained to ensure their knowledge, skills and practice in the delivery of care was kept up to date. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew it would be acted on.

The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals. People had access to the 'manager surgeries' and complaints process.

We received positive feedback from a visiting professional with regard to the care offered to people and professionalism of nursing staff.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. Nursing and care staff understood their roles and responsibilities and knew how to access support. Staff had access to people's care plans and received regular updates about people's care needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not supported by sufficient numbers of staff. Although environmental checks were carried out improvements were not made to ensure people were safe at all times.

People felt safe at the service. Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

People received a diet that met their individual needs. However some people were not satisfied with the temperature of the food or restricted choice of vegetables and sweets.

Staff were trained and supported to enable them to care for people safely and to an appropriate standard, and had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff provided care in a kind and sensitive manner; however there were times that people's dignity was not fully recognised.

Staff understood the importance of encouraging people's independence and their ability to make choices. People or their relatives were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People did not have access to meaningful individualised

activities that responded to their needs.

People received personalised care that met their needs because they and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes. People were confident to raise concerns or make a formal complaint when necessary.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The home had an open and friendly culture and people told us the registered manager was approachable and helpful. People using the service and relatives had opportunities to share their views on the service.

The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this. Premises audits were not used methodically to reveal faulty or broken equipment.

Braunstone Firlands Nursing 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 21 February 2017 and was unannounced.

The inspection team consisted of an inspector, a specialist nurse adviser and an expert-by-experience. A specialist nurse adviser is a qualified nurse who has experience of working with this service user group. This nurse specialist was a qualified mental health nurse and worked in a number of areas with older people. 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's area of expertise was the care of older people and people living with dementia.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information sent to us from people who used the service or their relatives and health and social care professionals.

We contacted commissioners for health and social care, responsible for funding some of the people that lived at the home and asked them for their views about the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection visit we spoke with the six people who used the service, six relatives, the area manager, the registered manager, the deputy manager, the nurse on duty and three care workers. We also

spoke with a visiting healthcare professional.

We looked in detail at the care and support provided for four people including their care records. We also looked at three staff recruitment records, and repair and maintenance records for the building, and the audits undertaken by the registered and deputy managers.

Requires Improvement

Is the service safe?

Our findings

At our inspection of October 2015 we found that there were not enough staff to ensure the safety of people at all times. At this inspection we did not find any improvements made to the staffing numbers.

Most of the people we spoke with did not voice any concerns over staffing levels. One person told us they enjoyed a daily outing to the shop, however a member of staff told us that this was only possible if a care staff could be spared. We observed people in the first floor lounge being supervised most of the time, with one person who needed frequent staff intervention.

One person said, "I think there's enough [staff] around." Another person said, "I've not noticed any problem with care staff around." Another person said, "They've usually got enough [staff] on." However one person said, "I get long waits for a shave or pad change, they just seem busy."

We found staff were well deployed until busy times when more people were required to complete specific tasks to meet people's needs. For example at lunch time, most of the staff in the home assisted with serving the meals and assisting people to eat. That meant the registered manager, four care staff and kitchen assistant helped people with their meals. There were two visiting relatives who told us they visited daily and helped their relative to eat their meal. Without the relatives' assistance people would have waited longer for their meal.

The lunch time meal was produced at a central kitchen and delivered to the home in a heated cabinet. Staff confirmed the lunchtime meals usually commenced around 12.30, but the delivery driver had been delayed in traffic. That meant the lunch was delivered at 1.05 pm, and was served on the ground floor at 1.25pm and on the first floor 10 minutes later, and were similar to the last inspection in October 2015. Due to the delays the delivery driver experienced, the company have purchased new delivery boxes which should assist in transporting the meals at a higher temperature.

The registered manager told us that as the lunch was served later than usual; the staff would serve the tea time meal later to compensate for the delay. Apart from the meal being served late, there was an issue with the time that the meal could be held for. Meals eaten later could affect people's health. We spoke with an environmental health officer about this. They assured us that they would follow up the time elapsed from the point of the meal being produced to the point of it being eaten. This was to ensure that the food produced in this way, is consumed within time laid down by environmental health law.

We also looked at the tea time meal provision where two members of care staff were deployed to the kitchen to prepare the meal, one from each floor. The lead nurse told they ensured they were available to assist care staff at that time. That meant there was one member of staff who covered each floor of the home. We ascertained there were several people on each floor of the home who required to be continually observed and some who required two staff for all personal care tasks and to aid their mobility. Staffing numbers left the potential that people's safety was not ensured at those times.

Following the inspection we were contacted by a director from the company, who shared the staff calculation tool used to ascertain staffing numbers. This reflected the staffing hours that people were 'allocated', but did not reflect people's dependencies so we could not be assured that adequate numbers of staff were employed to ensure people were cared for safely.

People we spoke with told us that they felt safe and secure living in the home. One person said, "I feel very safe, I get people wandering in [my bedroom] during the day and I don't like it. Its private, and I can close my door if I want." Another person said, "I'm alright, it's nice and secure up here. I lock my room at night, the nurse has got a key." A family member said to us, "She's safe due to two good reasons – it's a small place and hospitals are near."

We observed that there were no automatic closers on bedroom doors which would operate in the event of fire. We found bedroom doors propped open with wedges, furniture and coat hangers. That meant people safety could not be assured in case of an unplanned emergency such as a fire. We spoke with the registered manager who said they had ten automatic door closers fitted for people who remained in their bedrooms. However some of these people had now moved on and she was in the process of ascertaining which bedrooms now needed these to be fitted to ensure people were safe. They also told us this would be a planned programme to include all the necessary bedrooms. We were sent an email confirming their request to the maintenance manager, following the inspection.

On the first floor, the lounge door closers and those outside the lift, were poorly maintained and the doors banged shut when in use. We also noticed the extractor fans did not work in some toilet and bathing areas. When we reported this to the registered manager she had the doors adjusted and fans replaced before we completed our inspection.

We saw that there were three bedrooms on the ground floor without any call bell attached. We spoke with the registered manager who explained that two of the people were unable to use a call bell, and that was why their bedroom door was propped open. The third bedroom call point had been reported broken that morning, and was due to be repaired later that day. We saw the entry in the repairs book, and confirmed the repair was completed before we left the home.

The registered manager confirmed she completed regular checks of the building, fixtures and fittings. We viewed the on-going record of when items had been repaired or replaced. There was a maintenance team who undertook these repairs. Staff were aware of the procedure for recording and reporting faults and repairs. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.
We saw where repairs were recorded in a book, those were signed by the maintenance person who had carried out the repair. That meant the registered manager did attempt to ensure people's safety through regular safety checks.

Staff were able to tell us about people's individual needs, and the support they required to stay safe. People's care records included risk assessments, which were reviewed regularly and covered areas related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided clear guidance to staff in respect of minimising risk. For example one care plan indicated a person should only be assisted outside the home in a wheelchair. A visiting relative told us they were involved in discussions and decisions about how risks were managed.

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if

they suspected abuse. Staff we spoke with had received training in protecting people from harm and had a good understanding of what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff knew the different types of abuse and how to identify them. Staff were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on by the management team. They also knew which authorities outside the service to report any concerns to if required, which would support and protect people. The registered manager was aware of her responsibilities and ensured safeguarding situations were reported to the Care Quality Commission as required.

We spoke with the staff about what they would do if they suspected someone was being abused at the service. One member of staff said, "I would make sure the manager or [named staff] was aware and if they didn't follow it up I would go to safeguarding at the council."

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff. We found that the relevant background checks had been completed before staff commenced work at the service, which included the entitlement for nurses to continue to practice.

We spoke to people about how they were supported with their medicines. One person told us, "I know what tablets I take. The nurse waits as I'm lying down to swallow." Another person said, "The nurse stays with me while I swallow." Another third person said, "They wait by me. I can ask for paracetamol if I need it."

A visiting relative said, "I'm happy its [medicine] managed well."

We looked at the medication administration records (MARs) for six people and found all were signed appropriately to confirm their medicines had been taken. A signature sheet was in place which included staff initials to ensure that any missing signatures could be followed up. The MARs were kept with the medicines. These had people's photographs in place to reduce the risks of medicines being given to the wrong person. Information about identified allergies and people's preference on how their medicine was offered was also included. This helped to ensure that people received their medicines safely.

Where medicines were administered covertly or crushed and placed in food, we saw the registered manager operated the company policy of involving written approval from the GP and a discussion with the pharmacy to ensure this was safe. There are times when it is necessary to ensure medicines are administered to people covertly. Where the person does not have capacity, and refuses to take their medicine, a best interests meeting decides how the person should be offered these medicines. Though one person could have their medicine administered this way, nursing staff confirmed that they always offered the person medicines orally. This followed good practice, and ensured nurses adhered to relevant professional guidance.

People in receipt of 'as required' or PRN medicines had instructions added to the MARs to detail the circumstances these should be given and included the maximum dose the person could have in any 24 hour period. We observed the lunch time medication round and heard people being offered pain relief which was prescribed on an 'as required' basis. That demonstrated that staff understood when and how these medicines should be offered.

We found that medicines were stored securely and a record of storage temperatures for the medicines room and medicines fridge had been kept by staff. We saw the registered manager had arranged for an air conditioning unit to be fitted, which would ensure medicines were stored at the correct temperature throughout the year. Staff we spoke with knew the storage temperature limits and what to do if these exceeded or fell below the recommended maximum and minimum.

Good

Is the service effective?

Our findings

People we spoke with told us that the service was effective and they felt staff were capable in their role. One person said, "They're a sensible lot." One visiting relative said, "They seem very competent and on the ball." Another said, "As far as I can see, they're good." Another added "The staff have been lovely with [named]."

Staff said there was enough training and they did not feel they had any gaps in their knowledge. Records showed staff had received induction training after they commenced their employment. This was followed by training in safeguarding, moving and handling, food and hygiene, fire awareness, health and safety and mental health awareness. Training was reviewed regularly and staff were supervised to ensure their practice remained at a high standard and were competent to deliver an effective service. For example nursing staff were regularly observed administering medicines to ensure their practice followed the administration process in line with the company policies and procedures.

We saw from the training matrix that some staff had not completed some essential training. The registered manager said the training dates had been arranged and all staff training would then be updated. This information was made available following the inspection.

Staff felt communication and support amongst the staff team was good. There were regular staff handover meetings which provided staff with information about people's health and wellbeing prior to commencing each shift. Staff also told us they felt supported through regular staff meetings with the registered manager. Staff supervision was used to advance staff knowledge, training and development by regular meetings between the registered manager and staff group. Clinical supervision for the nursing staff was undertaken by a qualified nurse. Supervision benefited the people using the service as it helped to ensure staff were more knowledgeable and able to care and support people effectively.

People who were able to respond told us that staff usually asked for consent. We observed a nurse asking for permission to do a blood test on one person. One person said, "They always check with me." Another person said, "Most [ask for permission] say it automatically"

Throughout our inspection we saw staff offered people choices and sought consent before they offered assistance. We saw staff used moving and handling equipment and transported people appropriately using a wheelchair. We saw that staff spoke with people, asked for permission to undertake care and kept people informed of what they were doing next. That showed training was put into practice and staff communicated with people effectively

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 and hospitals 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. The care plans we viewed showed evidence of MCA assessments. There was evidence of applications for Urgent and Standard Authorisations in respect of DoLS procedures. The DoLS applications showed evidence of considering peoples' particular needs. For example there were applications to respond to needs such as ensuring personal care was provided and people leaving the care home.

Staff were knowledgeable about how they supported people to make daily choices and decisions on a regular basis. Staff told us they did this to ensure the person was aware what was being offered, for example personal care. This showed staff understood the need to gain people's consent and agreement which involved them making informed day to day decisions.

Feedback on the food provision was mixed, with a number of people commented that food was not always hot and voiced disappointment with the vegetable selection and some desserts. One person said, "We get a choice and it's quite hot. The portions are about right for me." Another person said, "The dinner isn't always as good as it could be – it's not hot enough. We're the last trolley stop (1st floor). We get asked a choice of two meals and the portion is ok. The quality is alright but not brilliant. Another person said, "I get the soft food but it's not often hot enough. It's cold when I get it. I don't get a choice and get a lot of yoghurt if it's a lumpy pudding that day." Another person said, "It took ages for them to tell me I could have soup [for lunch] as well. We get two choices but you never see things like cabbage – just carrots and peas. It's not always hot and the puddings are rubbish, and cold. I like hot custard over a pudding, not in a tiddly pot gone cold."

A visiting relative said, "Her weight has gone up lately, which is good. She has supplements to drink and she gets fed soft food by the girls (staff). She likes the puddings best and yoghurts." Another relative said, "Most of her food is puree – it's reasonable and I come to feed her most days. It's my happiness for her."

We spoke to the registered manager about the lunch time meal provision. The meal comes ready prepared from a central kitchen, and this home has their meals delivered last. We saw that the temperature of the meal was recorded on delivery, to ensure it was of a suitable temperature and safe to serve to people.
Menu preference questionnaires were in care plans and included people's likes and dislikes. That ensured the staff were aware of people's food preferences. Food recording charts were in place where staff suspected people were at risk of weight loss. People were asked if they would like to eat in the dining room, lounge or their bedrooms. We did not see anyone choose to eat in either of the dining rooms. Changes to the menu were arranged following the return of the annual quality assurance questionnaires.

During our inspection we saw lunch being served, where people had the choice of eating in the lounge or bedroom. People were provided with juice to drink while they were waiting for their food to arrive. We did not see where a variety of drinks were offered to people, though we were later told people had three choices. We spoke with staff who said that they knew people's food preferences, and gave drinks and meals based on that. The registered manager served the meals from a hot trolley. They said this was a good use of their time as she was able to see all the people in the home.
We spoke with staff who told us about the range of diets catered for which included pureed, fortified, and diabetic meals and a cultural alternative, and saw where meal supplements were provided where required. The registered manager said new items were added to the menu when people required them.

Although no-one told us they felt thirsty or voiced a concern about drink provision, we did not observe staff encourage people to drink or provide top ups. One person who spilt their squash prior to lunch was not offered a replacement drink. One person told us that the tea trolley did not always visit bedrooms. This person said, "I get tea and squash. I don't get a drink between lunch and tea though. Bedrooms get missed so I have to ring and ask." Another person said, "I keep cordial in my room. They bring the trolley round for hot drinks now and then." A relative said, "There's always a drink around for her but she has to be given it. She mostly gets juice and has a milkshake mid-morning and a yoghurt." Another relative said, "I get her through 2 cups of squash while I'm here. I ask if she's had some tea too and they say yes." We were not assured that people had enough to drink on a regular basis. We spoke with the registered manager who said she would monitor the drinks offered to people and encourage staff to record this when completing the daily records.

We looked at records for two people who needed specialised support with their nutrition and hydration. All care files included nutrition assessments and associated eating and drinking care plans. Monthly weights were recorded as part of the Malnutrition Universal Screening Tool (MUST), and results were routinely recorded. We saw there were routine assessments of choking risks and referrals to Speech and Language Therapists (SALT) and Dieticians in response to assessed difficulties. There was evidence in care plans of the use of dietary supplements, fortified meals and the consistency of food altered to ensure people were provided with an appropriate diet.

We spoke with a visiting health professional, who had been contacted by the home to assess three people with specific health conditions and risks such as swallowing difficulties and ensure the consistency of food supplied by the staff was safe and would prevent them from the risk of choking. They confirmed the changes put in place by the registered manager were appropriate, and ensured people's dietary intake effectively met their individual needs.

Records showed that people had access to a range of health care professionals including GPs, a specialist dementia team, speech and language (SALT) staff, district nurses, chiropodists, opticians, and dentists. If staff were concerned about people's health they referred them to the appropriate health care services and accompanied them to appointments. That meant that people were supported to maintain a healthy lifestyle.

People told us they had access to health care. One person told us, "The optician has been in and said my glasses were ok. The chiropodist does my toes [nails] but I do my own finger nails. The hairdresser comes once a fortnight."

Healthcare needs were identified and care plans were detailed and assisted staff in meeting peoples' health care needs. We saw the appropriate input and information from health care professionals was organised where necessary. There was evidence of care plan and health care plan reviews, these were routinely completed where required.

Good

Is the service caring?

Our findings

We observed people continued to be treated with kindness by a caring staff group. We observed staffs' interactions with people throughout the inspection showed that they were caring and helpful and that people were treated with dignity. People told us they felt that staff group were kind and friendly. One person said to us, "Oh yes, they [the staff] are nice to us." Another person said, "They're lovely." A visiting relative said, "I've never had a concern. I'm very grateful for the care."

We observed a care staff showing compassion when spending time with a person who had limited speech. The staff member knelt beside the person and stroked their hand and made eye contact, until they could say why they felt upset. That demonstrated a caring attitude by staff.

People who were able told us they were involved in decisions about their care and support. One person said, "They [staff] ask me if I'm happy. I feel involved (with my care)."

Visiting relatives told us that they felt involved with their relative's care planning. A relative said, "She had a DOLS assessment about six weeks ago, very thorough and I was involved. Her care plan was updated before her continuing healthcare assessment recently. I feel involved and they always tell me of any changes in her care." Another relative said, "I have regular contact with the nurse and her doctor. I feel involved."

The registered manager confirmed some people and their relatives continued to be involved in care planning and reviews. Staff confirmed people were asked to take part in care plan reviews but only a few of them chose to take part in this process. The registered manager added that relatives and close family members were informed when people's health or wellbeing changed.

Staff said there was a good staff team who knew people's needs and they all helped each other. They said they enjoyed working at the home and got on well with the people they supported. One member of staff said, "I am one of the newer staff, I know some staff have been here over fifteen years." That demonstrated a continuity of care.
We observed four care staff who each supported a person to eat. They were attentive, focused on the individual, assisted at a pace that appeared to suit the person and they spoke in a warm and reassuring manner throughout. We also saw staff prompted other people to eat their meal.

People told us that they felt staff respected their privacy and dignity. We observed care staff adjusted peoples' clothing to maintain their dignity, and noticed care staff knocking on bedroom doors before entering. One person said, "They'll knock my door even if it's open." Another person said, "I can shut myself in my room if I want some privacy. The staff will knock and then use their key." Another person said, "They knock before coming in mostly. I get the curtains shut when its wash time." A visiting family member said, "She has her door open mostly. If they need to see to her, I leave the room and they close the door and curtain."

People told us that, they were encouraged to retain their independence. One person said, "They let me do it

all really [personal care], I don't need much help." Another person said, "They make me do what I can manage, like bathing myself." We later ascertained from care staff, the person's bath was run for them and staff were on hand to assist if necessary.

We observed three care staff who assisted people to eat their lunch, and saw where they prompted other people to eat their meal. They told us this was important as it maintained people's skills and independence. The staff ensured the people's clothes were protected from food spillages, which assured their dignity. However people were not always asked if they wanted their clothes protected, or informed when staff were putting protective clothing on such as aprons. That demonstrated an inconsistent approach with people's dignity. This was shared with the registered manager who said she would take this up with the staff concerned.

Requires Improvement

Is the service responsive?

Our findings

At our inspection of October 2015 we found that there were few planned activities that were consistently available for people. There were activities folders in both the lounges, examples of the activities recorded were, watching television, listening to music, singing and reading the paper. There was inconsistent recording and on a number of occasions care staff had not recorded if people were offered or had declined the range of activities on offer.

At this inspection most people told us there were occasional outings and a monthly church service, but could not recall any regular activities. One person told us they were taken out on a daily basis.

One person said to us, "I get a bit bored sometimes. They do the odd thing on downstairs, and there's sometimes a monthly outing to the shops or for a coffee. I get communion once a month. Mostly I like to read my paper, or watch TV at night." Another person said, "Now and then they do something for us. I went on a trip to Loughborough recently I think. But otherwise I like to just read my paper and books." A relative told us, "(Named) sat in when there's been an entertainer here but I'm not sure if she was aware."

Although some people felt the care they were offered was individualised to them, others reliant on care staff for support felt their needs were not always addressed. We did not observe staff spending quality time with people or seeking to provide some meaningful stimulation.

Care plan information included people's preferences and abilities to undertake activities. We completed a number of observations, and saw a member of staff playing a game of cards with one person and another staff member accompanied someone else to go out periodically for cigarettes. We saw some people watched television whilst others read their daily paper or a book.

The registered manager showed us where she had purchased some individual games and pastimes, and showed us a special type of light which had been fitted to some people's bedrooms. She explained that the lights were used to reduce people's stress levels. However we did not see where staff were able to use these in one to one activities with people. That meant there continued to be an inconsistent commitment to providing meaningful social activities to people especially those with short attention spans to prevent them from the risk of isolation and stimulation.

We looked at people's care plans and found they included pre-admission assessments, which identified each person's individual needs. The registered manager said these were carried out before people moved into the home, which ensured that staff could meet the person's identified care needs as soon as they moved in.

Care staff had access to people's plans of care and received updates about their care needs through daily handover meetings. The care files we viewed were comprehensive, and included regular reviews of their care and support needs. However some of the care plans were not up to date and others had incorrect information. For example the care plan for one person who remained in bed stated the staff 'should always

be aware of the whereabouts of the resident'. The person was being cared for in bed and was not able to mobilise without the assistance of staff. We also saw two care plans had more than one person's name being used. We found a similar case was found at the last inspection where the person's name was used incorrectly. That meant the information had been copied from one care plan to another, but the names had not been changed.

Despite the inconsistencies included in the care plans staff we spoke with were able to tell us what care and support people required, and were aware of people's current needs. We spoke to the registered and area managers' about these inconsistencies and they told us a thorough audit of the care plans would be undertaken, and the care plans updated.

Care plans included risk assessments, which gave clear guidance to staff in respect of minimising risk. For example, guidance about the food intake in response to choking risk and use of specific equipment to lessen the moving and handling risk. There was evidence where people's additional health needs had been responded to by staff. For example, referrals made to the GP's, dietician, specialist nurses, Speech and Language Therapist (SALT) and community psychiatric nurse.

The complaints procedure was advertised in the foyer of the home, that along with the manager surgeries, formed a number of ways people could have any concerns dealt with by the registered manager.

No-one we spoke with could recall having to raise a formal complaint and felt that minor issues had been dealt with promptly. One person said, "I just complained when my laundry got lost a few weeks ago. My two nighties disappeared and only one has turned up." Visiting relatives told us, "I've not had a concern to raise properly. Just a few niggles that have always been sorted." Another relative said, "Never a complaint to raise."

The provider had systems in place to record complaints. Records showed the service had received four written complaints in the last 12 months. Complaints had been made about a poor variety of food choices for a specialised diet. The person who received the specialised diet now had this supplied by an external catering company, which had increased the variety of choice they could be offered. Outcomes had been provided for each complaint, and changes made to the service. There was a file in the foyer of the home that included a number of compliments about the care provided in the home. These were not dated so we could not ascertain how old these were or when they were compiled.

We saw there were regular meetings for the people and their relatives. These had been minuted and were available for people to refer to, and included the actions taken by the registered manager. For example, action taken where staff had addressed people inappropriately and other dignity issues.

Requires Improvement

Is the service well-led?

Our findings

All the people we spoke with were complimentary about the service and staff. They included relatives of people in the home and visiting professionals. People told us that the registered manager was regularly seen in the home and was easy to talk with. One person said to us, "She [registered manager] pops up now and then and has a talk with me." Another person said, "She walks round. I could talk to her with a problem." A relative told us, "She [registered manager] is really good, very supportive. She makes time to talk to us if we need to know anything."

The provider's procedures for monitoring and assessing the quality of the service operated at two levels. We viewed the checks and audits' the registered manager and staff conducted in order to ensure people received the appropriate support and care. The registered manager told us they conducted regular audits in order to ensure health and safety in the home was maintained. These checks included the medicines system, care plans, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements. We saw a number of records of the checks that had been undertaken that ensured the staff and caring process was safe for people. However these checks had not always revealed issues that we found at our inspection visit. These included where care plans had out of date information or incorrect name details included. There were also instances where environmental audits had not revealed outstanding maintenance issues.

The service had a registered manager who understood their responsibilities in terms of ensuring that we were notified of events a provider had a legal responsibility to notify us about. The registered manager had a clear understanding of how they wanted the service and they were supported by the staff group, the regional director and other head office staff.

All staff all had detailed job descriptions in place and had regular supervision meetings which were used to support staff to maintain and improve their performance. There were separate supervision arrangements for the nursing staff as the registered manager was not qualified to undertake these. Staff had access to the provider's policies and procedures.

The registered manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. The registered manager worked alongside staff to monitor changes to people and develop her understanding of staff roles and see where change was needed.

When we observed people who lived at the home and the staff who supported them, there were times that staff were engaged with people or meal tasks leaving others unsupervised. We found this continued to mirror what people told us and we saw at the last inspection. That meant where the provider had made any improvements following our last inspection, these had not been sustained.

Staff were aware of their accountability and responsibilities to care and protect people and knew how to access managerial support if required. There was a system to support staff, through regular staff meetings where staff had the opportunity to discuss their roles, training needs and could discuss how the service was

changing.

Staff told us that their knowledge, skills and practice was kept up to date. We viewed the staff training matrix, which showed that staff had received or had dates planned for refresher training. That included information on conditions that affected people who used the service and covered dementia awareness and behaviours that challenge.

Staff had access to people's plans of care and received updates about people's care needs through the daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, suggesting the care process was well managed.

We received mixed views on the regularity of meetings for people who used the service and their family or friends and no-one could recall being sent a questionnaire or survey. One person said, "They've not had a residents meeting for a long time." A relative said, "They've not done one [meeting] lately but there's been two or three in the past, about quarterly. It's a general forum really and petty things can get mentioned." Another relative said, "No meeting or survey that I'm aware of."

We saw there were meetings held for the people who used the service and their family or friends where they were also enabled to share their views about the service. There were also opportunities for people to attend the monthly 'manager surgeries'. This was to enable people to ensure when the registered manager was in the home, and available to speak with.