Care Quality Commission

Westlands Care Home Limited

Westlands Retirement Home

Inspection report

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Date of inspection visit: 13 and 14 July 2015
Date of publication: 27/08/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 13 and 14 July 2015 and was unannounced. Westlands Retirement Home is registered to provide accommodation without nursing for up to 51 people many of whom experience dementia. At the time of the inspection there were 49 people accommodated.

The service had recently appointed a new manager; they understood the need to submit an application to become the registered manager and planned to do this shortly. 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.

The service had expanded in June 2014, when an extension was added to the original building. The original building accommodates 35 people whilst the extension accommodates a further 16 people. The service provides

Summary of findings

both long term care and short-term respite care to people. The original building and the extension both contain a lounge and dining area in addition to people's bedrooms.

Staff had not identified all potential risks to people or put care plans in place to manage these risks. People with diabetes did not have diabetes care plans to provide staff with written guidance about how to manage their condition safely. Staff had not informed the GP when people had fallen in all cases that they should have. Staff had not always reviewed people's written care plans following incidents, to ensure any required updates were made, to manage risks to people.

People's daily records did not always reflect the actual care they had received. The manager had taken action to improve staff record keeping. However this issue had not been fully addressed to ensure people had accurate daily records of their care. The manager reviewed incidents but there was a lack of robust trends analysis to identify potential areas of risk to people. The manager produced a monthly quality assurance report for the provider but this process was not sufficiently in-depth to fully assess and monitor the quality of the service people received.

Some relatives and staff provided negative feedback on staffing levels but people themselves, and the majority of relatives and staff felt staffing was sufficient. Staffing levels were observed to be sufficient to meet people's needs.

The provider operated safe staff recruitment practices. Staff had completed an induction to their role and were required to undertake regular training and supervision. People were supported by suitable staff who felt sufficiently supported in their role.

People were safeguarded from the risk of abuse. Staff had completed relevant training and understood what action they should take to safeguard people. Safeguarding incidents had been reported by the manager to the relevant authorities to keep people safe.

Staff who administered medicine had received training. Learning had taken place following a medicines incident and changes implemented. People's medicines were managed safely.

People were protected from the risk of infection. Staff had received relevant training and had ready access to equipment to prevent the spread of infection. The service was clean.

The manager had identified areas for improvement in relation to the quality of the lunch time experience for people who lived with dementia. Some changes had already been implemented but further improvements were required to meet people's needs effectively at lunchtime.

A programme of renovation was planned for the original building and this was due to commence once quotations had been obtained. The provider planned to use improvements to the internal environment to improve the appearance of the service for people.

People were weighed regularly and action was taken if they were assessed as at risk from malnutrition. Where required, people had been referred to the dietician and their food and fluid intake had been monitored. People's pressure ulcers were managed effectively. Staff had sought relevant advice from the district nurses and used equipment appropriately to manage people's pressure ulcers.

Where people lacked the mental capacity to make specific decisions staff were guided by the principles of the Mental Capacity Act 2005. This ensured any decisions made were in the person's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLs applications had been submitted for people to ensure restrictions on their liberty, to keep them safe, were legally authorised.

People's relatives provided mixed feedback about how caring staff were. They told us the long-term staff were very caring but that some of the new care staff did not interact consistently with people. Some care staff chatted with people positively and warmly whilst others were observed to focus on providing people's care. People experienced inconsistency in the level of social interaction from some staff.

People's records provided staff with clear documentation in relation to their personal preferences about their care.

Summary of findings

People were involved in making decisions about their care where possible and their choices were respected. Staff treated people with dignity. They spoke with people respectfully and ensured their privacy was upheld.

People's care needs were thoroughly assessed prior to them being accommodated. The provider ensured they only agreed to accommodate people whose needs staff could meet. People had clear care plans which they or their families had been consulted about. Their care plans were reviewed regularly to ensure they remained relevant. Staff read people's care plans and understood their care needs.

Some relatives felt there had been a reduction in the amount and quality of activities. People were able to access a range of activities during the week, however, they were not all publicised to ensure people knew what was taking place and where.

People and their relatives had accessed the provider's complaints process. The manager had responded to complaints received at an individual level. They had also taken action when a trend in complaints about laundry had been identified in order to improve people's experience of the laundry service. People's views of the service were sought and recorded during their monthly review where possible. People's views were also sought through the annual quality survey and meetings. People's views had been sought and action taken in response to issues raised.

There had been a recent change in management and growth in the size of the service. Although staff felt supported by the management, some people's relatives felt management should be more visible on the floor. There were processes in place to ensure information was shared between staff on the floor and the manager, however, these were not always fully effective. The provider was reviewing how to make the team leader role more robust in order to provide a stronger level of direct management of care staff on the floor for people.

The new manager was working to create an open and transparent culture. Staff told us they felt supported and able to speak up about any concerns they might have. People were cared for by staff who felt able to speak out about issues.

We found breaches 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.

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?
The service was not always safe.

Risks to people had not always been identified or responded to appropriately by staff to ensure people received their care safely.

Feedback regarding staffing levels was mixed. People were cared for by an adequate number of staff.

People were safe from the risk of abuse. Staff had received training and understood their roles and responsibilities.

People received their medicines safely from staff who were trained.

People were kept safe from the risks of acquiring an infection.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff received an induction into their role, ongoing training, supervisions and an appraisal. People received their care from staff who were supported in their role.

People received effective pressure ulcer care but the lunchtime care of people who experienced dementia could be further improved.

People's weight was monitored and staff ensured people had received enough to eat and drink.

Staff followed legal requirements where people lacked the capacity to consent to decisions about their treatment, to ensure their rights were protected.

Staff supported people to access a range of health care services.

Requires improvement

Is the service caring?
The service was not consistently caring.

People did not consistently experience positive relationships with all care staff as some care staff focused on the delivery of people's care rather than on interacting with people.

People had been supported to express their preferences about their care and were able to exercise choice.

People's privacy and dignity were respected and promoted.

Requires improvement

Is the service responsive?
The service was responsive

Good

Summary of findings

People's care needs had been assessed prior to them being accommodated by the service. People had care plans in place to address their individual needs.

The provider had a complaints policy which people used to make any formal complaints. People's complaints were actioned and responded to appropriately.

Is the service well-led?

Requires improvement

The service was not always well-led.

People's records of their care were not always complete or accurate.

There was a lack of a robust process to fully audit the service to identify areas for improvement or to monitor underlying incident trends which might impact upon people's safety.

The manager and the deputy were not visible enough on the floor and would have benefitted from a better overview of staff practice. The providers were trying to address this by reviewing the role of the team leader.

The manager was working with staff to promote a positive culture, staff felt able to speak out about issues.

Westlands Retirement Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 13 and 14 July 2015 and was unannounced. The inspection team included two inspectors, a specialist advisor with experience of nursing 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.

Before the inspection the provider 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. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. This year two concerns have been raised with the Care Quality Commission about people's experience of respite care at the service.

Prior to the inspection we spoke with two nurses, a GP and received feedback from a social worker. Overall their feedback about the service was positive. However, some concerns were identified about the level of information sought by the provider at people's pre-admission assessment, falls reporting, staff turnover and the quality of daily record keeping.

During the inspection we spoke with six people and seven people's relatives. We also spoke with the manager, deputy manager, the provider, ten care staff, the activities co-ordinator, the chef and two ancillary staff. We spoke with three visiting nurses and one GP.

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 course of the inspection we spent time observing staff interactions with people in both the original building and the extension. We observed a staff shift handover and the morning department handover.

We reviewed records which included eight people's care plans, three staff recruitment records, ten staff supervision records and records relating to the management of the service.

The service was last inspected in March 2014. When the service was inspected to check whether action had been taken in relation to breaches found at the October 2013 inspection. The service was found to have met the requirements of the regulations.

Requires improvement

Is the service safe?

Our findings

Some people experienced type two diabetes which is diet controlled. Staff including the chef knew who had type two diabetes. However, people did not have a diabetic care plan to provide guidance for staff about what support they required to manage their condition or signs that might indicate they were becoming unwell. The service did not have a diabetes policy and had not provided staff with diabetes training to ensure they understood how to manage this risk. People were at potential risk of not having their diabetes managed safely.

People had risk assessments to manage various risks such as from moving and handling and pressure ulcers. However, staff did not always take appropriate action when risks to people were identified. One person had difficulty swallowing and needed to be referred to the Speech and Language Therapist. This referral had not been made. We spoke to the manager who ensured this was done during the inspection and action was taken to manage the risk to this person.

Staff followed the provider's falls protocol to monitor people for any post falls complications. The GP was contacted if people hit their head. However, the GP was not routinely notified of all falls in accordance with the local authority guidance to enable them to assess if further action was required, such as referring the person to the falls clinic for assessment. People's falls care plans had not always been reviewed following a fall, to ensure staff had access to up to date written guidance about how to keep people safe from the risk of further falls.

One person choked whilst eating their lunch. Staff took the correct action; however, they failed to complete an incident form. Staff verbally passed this information on to staff at the next shift handover so that they were aware of the risk to the person. However staff did not inform the manager and we had to. Staff failure to follow incident reporting procedures to ensure the manager was made aware of the incident and could take any required action, potentially placed this person at risk of choking again.

A person had recently left the building without staff knowledge. This had not been reported to the local authority to enable them to determine if any further action was required to keep the person safe. Nor had their care plan been reviewed to see if it required updating. We brought this to the attention of the manager who took appropriate action, to update the person's care plan. They amended the incident form to ensure staff were prompted about who to inform about incidents.

The failure to provide care in a safe way for people by assessing the risks to them and taking action to mitigate the risks was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback regarding staffing levels was mixed. Two people's relatives were not satisfied with staffing levels and perceived a difference in the care provided for people in the original building and the extension. Two staff said staffing levels were not adequate. However, the majority of relatives and staff felt there was sufficient staffing. People spoken with did not raise any issues about staffing nor did they say they had to wait for support. Call bells were responded to in a timely manner. People's care was provided by sufficient staff.

The manager said five care staff were allocated to the original building and three care staff to the extension, with a team leader working across the service on the early shift. Records confirmed this. There were 34 people in the original building, a ratio of 6.8 people to each member of staff. In the extension there were 14 people, a ratio of 4.6 people to each member of staff. People were able to spend time in either of the two lounges therefore the number of people in the extension during the day and cared for by staff there was often higher than 14. There were sufficient staff to meet people's needs. The manager did not use a dependency tool to determine the required level of staffing for the service. Use of a dependency tool would have enabled the manager to provide written evidence of the adequacy of staffing across the service to meet people's needs. People were cared for throughout the building by sufficient staff.

A GP and two nurses commented there had been a high turnover of staff. The provider's information return showed 13 out of 35 staff had left in the past year. The manager told us nine new staff had been recruited and a further four vacancies were being advertised. These vacancies were currently being covered by regular agency staff. The provider had taken appropriate action to ensure adequate staffing levels were maintained.

Requires improvement

Is the service safe?

Two people's relatives told us some of the new care staff did not have good spoken English skills. The manager informed us that an applicant's level of English was assessed at interview and they were required to undergo a written English test. When staff were heard speaking, they had an adequate level of English to understand people, and to interact with them. The provider had taken reasonable measures to ensure staff had an adequate level of English to communicate with people.

Staff had undergone comprehensive recruitment checks as part of their application and these were documented. These included the provision of suitable references, proof of identity and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. People were protected, from unsuitable staff, as the provider operated safe recruitment processes.

Most people and their relatives said they felt people were safeguarded from the risk of abuse. One commented "It's absolutely safe here." One relative did express a concern that some small items had gone missing. Action was being taken to address this. The manager had correctly reported safeguarding incidents to the relevant authorities to ensure people were safe. They had worked with external agencies to ensure safeguarding alerts were investigated. Staff had completed safeguarding training and understood the procedures to follow should they suspect a person was being abused. One told us, "I would always report something to my manager." People were kept safe from the risk of abuse as staff understood their role.

People did not express any concerns about medicines management. Staff told us they had received medicines training, which records confirmed. People's medicines were stored securely and at the correct temperature. Staff administered people's medicines safely. People's medicine administration records had been completed correctly and signed once the person's medicine had been administered. There were processes in place to ensure medicines were disposed of safely. The manager told us that following a medicines incident they had reviewed the processes and were changing pharmacy in order to improve the system used to administer medicines. The provider's community pharmacist last audited medicines on 28 January 2015. The pharmacist did not identify any areas that required action. People received their medicines safely.

People and their relatives were happy with the cleanliness of the service. The service was clean apart from the lounge carpet in the original building which was stained and due to be replaced. The hairdressing salon had not been cleaned; this was brought to the attention of the manager and the salon was clean when we carried out a further check. The service had a nominated infection control lead who was responsible for this area, including staff training. Staff told us they had received the appropriate training and had access to equipment to reduce the risk of infection. The provider's infection control policy was in line with current guidelines provided by Public Health England. People were protected from the risk of infection.

Requires improvement

Is the service effective?

Our findings

Staff underwent a five day induction period, during which they familiarised themselves with the provider's policies, protocols and working practices, records confirmed this. Staff worked alongside more experienced staff until they were confident to work alone and told us they felt well supported. All staff were able to access training in subjects relevant to the care needs of the people they were supporting. Staff told us they were satisfied with the training opportunities on offer. Staff received regular supervision in accordance with the provider's requirements. Annual staff appraisals to enable staff to reflect on their performance in their role and to identify their objectives for the coming year. People were cared for by staff who were supported in their role.

A person had experienced a pressure ulcer. There was guidance for care staff within the person's care plan on how to manage the pressure ulcer and staff had received training to ensure they understood what support people required. There was evidence of engagement with the district nursing service to manage the pressure ulcer, which had subsequently healed. This person received effective care from staff to meet their needs in relation to pressure ulcer management.

Not all aspects of people's care were delivered as effectively. Staff had received training in how to care for people who experienced dementia. Records showed the manager had identified the practice of asking people what they wanted for their meal the night before did not meet their needs as people forgot what they had chosen. The manager had taken action and changed staff practice, to ensure people were supported to make choices about their meals appropriately. Staff showed people the two main meal choices shortly before lunch. People in the original building who required support to eat their meal had been identified and were seated at a table with a member of the care staff to support them. However, staff seated people for lunch much earlier than the lunch service started and some people became restless. There was no music to distract people; the tables were not laid with a tablecloth, menu or condiments to enhance people's experience and to act as a prompt for lunch. The manager told us the lunch service had improved since they had discussed this issue with staff, which records confirmed. However, on this occasion staff had been called away to deal with visiting professionals causing lunch to be served late. Protected mealtimes had been instigated to ensure staff could focus on meeting people's needs. However, several professionals still visited people at lunchtime on the day of the inspection. This interrupted the lunch service. The manager had taken measures to improve the lunchtime experience of people who experienced dementia but this could be improved further.

No one had any complaints about the quality of the food but one person's relative told us they were concerned about their relative's weight loss. Records showed people had been weighed regularly to monitor their weight and their Malnutrition Universal Screening Tool (MUST) score was calculated monthly. MUST is a screening tool to identify adults, who are at risk from either malnourishment or being overweight. A person's records demonstrated their weight loss had been identified and addressed leading to their weight increasing. People had been referred to the dietician in relation to their weight loss where required, to ensure their needs were assessed. People who had been identified as at risk from weight loss or who needed their fluid intake recorded had relevant charts in place to monitor their intake. The design of the fluid chart did not include a total to enable staff to record the amount of fluid the person had drunk in total across the course of the day. There was no evidence people had not been supported by staff to drink enough but the form for recording people's fluid intake could have been improved to assist staff in their monitoring. Risks to people from malnutrition and dehydration were assessed regularly and action taken if people were assessed as at risk.

The chef told us they had a three week rolling menu. The meals were all made on-site. They were aware of people's dietary requirements and personal preferences which were documented. There were two choices for the main course at lunch and choices for dessert. People did not all know there was an alternative option for dessert when asked and may have preferred this if they had been made aware of what was available.

Staff had either received training on the Mental Capacity Act (MCA) 2005 or this was booked and guidance was available to them. The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff had a good understanding of issues surrounding consent, people's right to take risks and the

Requires improvement

Is the service effective?

necessity to act in people's best interests when required. The service had access to the local authority Mental Capacity Act 2005 toolkit which they had used to assess people's capacity to make various decisions about their care including in relation to care, medicines, going outside and welfare for example. A person's records contained a copy of their Power of Attorney for care and welfare to ensure staff were aware of who they were legally required to liaise with in relation to decisions about the person's care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The manager had submitted DoLs applications for everyone, which they were waiting to be processed. As people lacked capacity to consent to their care, were under constant supervision and were unable to leave the service, this ensured restrictions on their liberty were legally authorised.

Some relatives and staff expressed concern that there had been a lack of investment in the service in recent months. The provider told us they were about to commence a refurbishment programme of the original building, which would include re-decoration in addition to the upgrading of bathrooms. Contractors were assessing the works and they were awaiting a quotation in order to make improvements to the original building for people.

There was a picture on people's bedroom doors to help them identify their room. Although people accommodated experienced dementia, there was no use of 'memory boxes' which contain items of significance to the person to help people recognise their bedroom or other prompts. In the original building people's bedroom doors were all painted the same colour, whereas in the extension they were different colours which made it easier for people to find their bedroom. The providers told us they would take this into account in their planned re-decoration programme.

Two relatives expressed concern about the keypads which prevented people from moving freely from one part of the service to the other and the separation of the two gardens between the original building and the extension. People needed to access both sides of the service if they wanted to attend an activity in the other lounge and staff supported them to do this if they wished. The manager informed us these measures were in place for people's safety as the perimeter of the extension garden was not as secure as the garden for the original building and therefore people could leave the premises unauthorised. The security measures in place ensured people's safety.

Requires improvement

Is the service caring?

Our findings

People's relatives provided mixed feedback in relation to how caring staff were towards people. Some were very positive, particularly about the staff who had worked at the service for a long-time. Other relatives said some of the new care staff in particular did not interact sufficiently with people and only spoke with people when directly providing care, our observations confirmed this. Some staff were seen to stand around with their arms folded when they were not providing people's care; instead of taking the opportunity to sit and speak with people and provide them with social interaction.

Staff were observed at lunchtime in both dining rooms to be inconsistent in their approach as they supported people. Not all staff were sensitive to people's needs as they served lunch. Some staff put a meal down in front of the person without interacting with them, telling the person what the meal was or checking if they needed assistance to cut it up. Some staff chatted in a friendly manner with people as they supported them to eat their lunch. Whilst other staff focused on the task of putting food into the person's mouth and assisted people in silence. Some people missed out on an opportunity for social interaction with staff as they ate their meal, whilst others had a pleasant sociable experience. A person was heard shouting and distressed. Two different care staff tried to interact with the person. However neither of them tried to distract the person from the source of their distress. Staff responded to this person's distress but not in a way that was meaningful for the person. People experienced inconsistent support from some of the new care staff.

People's care records contained a summary of what a good or a bad day looked like for them, to enable staff to understand what experiences they liked and what they disliked. People's preferences were recorded within their care plans for example, in relation to the gender of staff they preferred to provide their care. Two relatives raised concerns over the number of new staff that were male. Records showed of the 28 care staff, six were male. On each shift there were both male and female staff to meet people's preferences. The providers and the manager were aware of relative's views and told us an extra female care staff was about to join the staff team. There were sufficient staff of both genders to meet people's personal preferences.

People's communication needs had been recorded and information about people's personality had been noted. For example, whether they were outgoing or preferred to spend time on their own. Care plans contained guidance on how to communicate with people. People's care plans documentation included a document "How I like to spend my day". This noted people's daily routines across the course of the day. Staff were provided with relevant information to enable them to understand people's needs and preferences in the delivery of their care.

People told us they were able to express their views and to make decisions about their care. For example, they could choose whether to come into the lounge or dining room, whether to eat in their rooms or what clothes they wanted to wear. A person was occasionally noted to refuse personal care. Their decision was respected and further attempts to assist them were made later, records confirmed this. Another person occasionally refused to go to bed; staff respected their choice, but encouraged them to go to bed. People's preferences and rights were respected.

Staff were observed to knock and await a response before entering people's bedrooms. Staff respected that they were about to enter people's private space. People's personal care was provided in private with the door shut. Staff were observed asking people's permission before taking away plates, putting a protective cover on them for lunch or serving drinks. Staff ensured they spoke to people respectfully and sought their permission. People had individual rooms, with the exception of couples who chose to share a double room.

People's relatives visited them across the course of the day. People's care plans addressed what support they required to maintain contact with their families such as support to use the telephone. People were supported to maintain contact with their families.

Good

Is the service responsive?

Our findings

Feedback received from professionals prior to the inspection identified a concern in relation to the robustness of people's pre-admission assessments. Pre-admission assessments were required to ensure the provider was able to meet people's needs within residential care. People's records showed their care needs had been assessed prior to their admission. The admission documentation covered various aspects of people's care needs. These included areas such as diagnosis, continence, communication, memory, personal care, skin care, falls and behaviour. The documentation also covered pain, orientation, eyesight, hearing, sleeping, medicines, eating and drinking. The deputy manager told us, following a previous incident, in relation to the suitability of the service to meet a person's needs they were careful to ensure the service only accepted people whose needs they could meet. They told us they reviewed the information other agencies provided to them as part of the assessment. Then they ensured they completed a full assessment of the person's needs and checked if the information provided to them was accurate. The manager confirmed they had not admitted people whose needs they could not accommodate. People's needs were thoroughly assessed to ensure staff could meet people's needs prior to their admission.

People told us they were involved in their care plans. A person's relative told us "Staff know her well." People had care plans in place to address their care needs as identified by their pre-admission assessment. People's care records showed their relatives had been asked to provide details of their life and work history to contribute to their care planning and staff knowledge of the person. The care plans incorporated personal details about people and their specific needs. A person had complex care needs. Their care records contained detailed guidance for staff about how to meet their needs and how to support the person to manage their behaviours which could challenge staff. People's level of independence was reflected within their care planning. It had been documented what people could do for themselves such as shaving and what care they needed support with for example, bathing. One person's plan stated "I can get myself washed and dried with prompts from staff." People's care plans were individualised to meet their needs.

People's records contained a care summary sheet which provided an overview of the person's care needs to ensure staff had access to key relevant information about people upon which to base their care. Staff had a handover between each staff shift. This provided the opportunity for staff to handover key information about people and actions that were required to the new staff shift. Staff told us they worked on both sides of the service to enable them to get to know all people and their needs. Staff told us they had time to read people's care plans and were informed about changes to people's needs. Staff understood people's care needs.

The manager and the deputy manager told us they had set up a schedule of reviews to ensure people's care was reviewed regularly, records confirmed this. People were each allocated a keyworker; this was a member of staff who had overall responsibility for their care. The keyworkers completed a monthly report on the person's care needs. People's care needs were regularly reviewed.

Some people's relatives said they felt the provider spent insufficient money on activities and that the quality and amount of activities had reduced in recent months. The activities co-ordinator ran activities for 20 hours a week across four weekdays. They provided an activity in one lounge in the morning and then in the alternative lounge in the afternoon. They also provided activities for people on a one to one basis. The manager told us they were recruiting a second activities co-ordinator to provide activities for people at the weekend, to enable people to access social activities across the seven days of the week, although this staff member had not been recruited as yet. In addition a person visited weekly to do flower arranging with people. There was an external entertainer once a week on the day the activities co-ordinator did not run groups and church services were held fortnightly. A 'Pat dog' was brought to the service regularly to enable people to have therapeutic contact with animals. There was a lack of a written activities schedule for the week outlining the activities programme and location. The provision of a schedule might have provided reassurance to people's relatives about the actual level of activities taking place. People were able to access a range of activities across the course of the week.

People's relatives told us they felt able to make a complaint if they needed to. The provider's complaints policy and procedures were displayed in the communal areas for

Good

Is the service responsive?

people and their relatives to access if required. Staff were clear about their responsibilities in relation to the management of people's concerns and complaints. Eight complaints had been received this year, in relation to issues such as the quality of care, the maintenance of the home and the running of the laundry. The manager said that, since they had commenced their role, they had received a number of complaints about people's laundry. They told us they had taken action in response to these complaints. This included expanding the laundry facilities and reviewing and improving the laundry processes. As a result there had been a reduction in complaints received about laundry.

Complaints had been resolved in a timely and satisfactory manner. The manager had written to each complainant with an action plan, where necessary, outlining the steps they were taking to prevent further issues. People felt able to raise complaints and where they had done so they had been responded to appropriately. The manager had taken action when they had identified trends in relation to complaints.

People's monthly keyworker report included a section to document people's views where they were able to express them. This gave people the opportunity to give their views on the care they had received. The last resident's quality control survey was completed in December 2014. People were asked a range of questions about the quality of the service and the results were analysed. Where people had identified issues these had been addressed. The providers informed us they were in the process of giving people this year's survey. A relatives meeting was planned for 5 August 2015. People and their relatives had been provided with opportunities to give their views of the quality of the service provided.

Requires improvement

Is the service well-led?

Our findings

The care records for the person observed to choke stated they had "Eaten and drunk quite well." Their care notes did not provide a complete or accurate record of what had happened to them at lunch. Other people's care notes did not accurately describe the care they had received. A person had been observed to refuse their lunch choice but their notes again stated they had "Eaten and drunk quite well." Following the inspection the manager informed us the person had actually been offered an alternative meal which they had later eaten, but their records did not accurately reflect this information. People's notes documented "All care given" without stating what aspects of their care had been provided. A person had stayed at the service for respite care and their records were not comprehensive and their daily notes did not document details of their care provided. People's care records did not always provide an accurate or complete record of their care, to ensure the maintenance of robust records. The manager told us the standard of record keeping had been addressed with staff; however, this issue had still not been resolved for people.

The manager reviewed incident reports and then collated a report of the numbers of each type of incident. For example, skin damage, bruising, falls, fractures, people absconding and medicine errors. The manager was able to describe actions they had taken in response to individual incidents to keep people safe. However, there was a lack of evidence to demonstrate they had analysed incidents and trends over time and documented their findings in order to identify and assess risks to people.

Records showed a range of audits of the service had been completed by the previous manager. They had completed specific audits of infection control, maintenance, accidents, medicines and care plans. However, this method of auditing specific aspects of the service had stopped when the previous manager left. Records demonstrated that the new manager completed a single monthly audit covering all aspects of the service for the provider. This included care plans, incidents, medication, complaints, care and staffing, and contained a comments and actions section. However, there was a lack of a structured process to audit specific aspects of the service such as records, in order to identify when quality of service or people's safety were compromised. The new manager's monthly audit report had not robustly addressed the issues found in relation to people's safety or record keeping.

People's care notes were stored in lockable cupboards on each side of the building. At the beginning of the inspection these cupboards were found to be not locked. They were checked across the course of the inspection by the manager and were then locked. Staff had not always ensured people's records were secure.

The failure to securely maintain accurate and complete records of people's care, fully assess, monitor and improve the quality of the service provided and, have effective systems to manage risks to people, was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new manager had recently been appointed to the service. Some relatives expressed concern that this manager was not sufficiently visible around the service. The manager told us they spent time observing staff practice but they thought they would benefit from spending more time on the floor. The provider told us they spent three days a week at the service. They said they spent time observing practice, speaking with people, relatives and staff. They were observed to do this across the inspection; people recognised them and appeared happy to talk to them. Staff felt the management team were broadly supportive and offered clear leadership. Staff were satisfied with the support from management.

The provider told us there had been a requirement for senior management to spend increased time attending to management tasks, due to the recent growth of the service and the change in manager. Therefore although they spent time on the floor observing care, they had less time available to do this than the previous manager. There were processes in place to facilitate the communication of issues from staff on the floor to management. These included a new daily morning meeting between the manager and all departments to share information about people and an afternoon handover of information from the senior staff to the manager. However, information was still not always shared with management, for example, when incidents had taken place which affected people's safety. The provider recognised there was a gap between management and staff on the floor. They informed us they were reviewing the management structure with a view to strengthening the

Requires improvement

Is the service well-led?

middle management team leader role in order to provide a more robust and direct link between management and care staff. People's quality of care would have benefited if senior management had spent more time directly observing staff practice.

There had been a lot of changes within the service in relation to ownership, management, growth in number of people using the service and changeover of staff. The manager told us they were working on developing an open culture within the service. They ensured staff informed people's relatives of any incident involving their relative in accordance with regulatory requirements and records confirmed this. The manager told us they had an open door policy and were open to staff suggestions to improve the service. Staff said they felt able to share any concerns they had with the manager in confidence. The manager recognised there were issues with communication between care staff and management and were working to address these to improve the service for people.

The provider did not have a mission statement or a statement of values. Their statement of purpose set out the aims and objectives of the service for people. These included: the provision of high quality, person centred care which respected people's rights, needs and values. Some aspects of the service needed to be improved such as people's safety and records in order for the service to fully meet their objectives in relation to the high quality delivery of people's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment The failure to provide care in a safe way for people by assessing the risks to them and taking action to mitigate the risks was a breach of regulation 12 Safe Care and Treatment 12(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The failure to fully assess, monitor and improve the quality of the service provided in order to manage risks to people. Or to securely maintain accurate and complete records of people's care was a breach of regulation 17 Good Governance 17(2)(a)(b)(c).