Burlington Care Limited

The Limes

Inspection report

Scarborough Road
Driffield
East Yorkshire
YO25 5DT
Tel: 01377 253010
Website: www.burlingtoncare.com

Date of inspection visit: 11 and 12 August 2015
Date of publication: 08/01/2016

Ratings

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

Overall summary

We carried out this inspection on 11 and 12 August 2015 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting. We commenced the inspection at 7.00 pm on 11 August 2015 in response to some information of concern we needed to follow up. This provided the opportunity to observe practices and talk to staff across both day and night shifts.

The last inspection of the home, which was carried out on 9 June 2015, was a follow up inspection to check whether the registered manager had made the necessary improvements to the services recruitment and selection

Summary of findings

procedures. We found that while improvements had been made we did not revise the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

The service is registered to provide personal care and accommodation for 85 older people and there were 83 people living at the home on the day of the inspection. The home is situated close to the town centre of Driffield, in the East Riding of Yorkshire and is located within its own grounds. The Limes has a residential unit and a dedicated dementia unit that accommodates 33 people who are living with dementia. The units are staffed separately.

The provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 1 August 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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 told us they received training relevant to their job and training records supported this. However, staff also told us that at times they have to manage people who display behaviours that challenge others. Staff told us they had not received training in physical interventions such as safe hand holds or break away techniques. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety or had witnessed abuse. Staff told us they had no concerns regarding any of the practice they had observed by their colleagues.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health based professionals in the community.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home. However we were told that there were times when sickness was not always covered. The home had taken steps to alleviate this concern and planned to increase staffing levels.

Incident and accidents in the home were accurately recorded, monitored monthly and appropriate action plans were put in place to try to minimise any reoccurrence.

Management and senior care staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and understood the requirements of the Act which meant they were working within the law to support people who may lack capacity to make their own decisions. However the service needs to ensure that MCA guidelines are fully followed in relation to the recording of best interest decisions. We made a recommendation about the recording of best interest meetings.

The registered manager was aware of guidance in respect of providing a dementia friendly environment and progress had been made towards achieving this. Staff had undertaken training on dementia awareness. This helped them to understand the care needs of people with a dementia related condition.

Following the last inspection on 9 June 2015 we saw that staff continued to be recruited in accordance with the homes policies and procedures. This meant that people were protected from staff that may be unsuitable to work with vulnerable adults or children.

Care plans were well written and updated on a regular basis. This ensured they were reflective of the needs of the people they were written for and that staff had access to the most relevant information.

People's nutritional needs had been assessed and responded to. People told us that they were satisfied with the meals provided by the home. We saw people who required support with eating received this in a dignified manner.

Summary of findings

We saw the recording of some documentation including food, fluid and repositioning charts were poorly completed and in some instances charts were completed retrospectively. We made a recommendation about the need for accurate recording on documentation.

We found that medicines were safely managed and administered, and people received their medication on time. We have made a recommendation about the use of 'as and when required' (PRN) medication.

We observed good interactions between people who used the service and the care staff throughout the inspection. People told us that staff were caring and this view was supported by the visitors we spoke with.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. However the home acknowledged that there had been some delay in providing the results of the staff survey to staff members.

People who lived at the home, visitors and staff told us that the home was well managed. All of the staff apart form one told us they found the homes manager approachable and that they felt confident to raise concerns and were well supported.

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?

Good

The service was safe.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise abuse and keep people safe from harm.

Risk assessments were in place and were reviewed regularly which meant they reflected the needs of people living in the home.

People's medicines were stored securely and most were administered effectively.

Incidents and accidents were managed effectively and action was taking to minimise risk.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received most of the training required to effectively carry out their roles. However training in behaviours that challenge is required.

The service needs to ensure that they follow guidelines to ensure the accurate recording of best interest decisions.

Staff recording of food, fluid and repositioning charts was inconsistent and in some instances charts were completed retrospectively.

People were provided with a choice of nutritious food. People were supported to maintain good health and had access to healthcare professionals and services

Is the service caring?

Good

The service was caring.

People told us they felt supported and well cared for.

We observed positive interactions between people who used the service and staff on both days of the inspection.

People were encouraged to be as independent as possible, with support from staff. Their individual needs were understood by staff.

Is the service responsive?

Good

The service was responsive

The service responded to people's needs and a range of planned activities were available to people who used the service.

Summary of findings

People's care plans recorded information about their previous lifestyles and the people who were important to them. Their preferences and wishes for their care were recorded and known by staff.

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Good

The service was well-led

The service was well organised which enabled staff to respond to people's needs in a planned and proactive way.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Regular staff meetings took place and were used to discuss and learn from accidents and incidents.

The Limes

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 was carried out over two days on the 11 and 12 of August 2015 and was unannounced.

The inspection team consisted of three Adult Social Care (ACS) inspectors and one inspection manager.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home.

The provider was not asked to submit a Provider Information Return (PIR) prior to the inspection, as this was not a planned inspection. A PIR is a document which the provider completes which provides some key information about the service. We carried out the inspection at short notice because we had received information of concern that we needed to follow up.

During the inspection we spoke with seven people who lived at the home, three visiting relatives, eleven members of staff, the registered manager and the registered provider. We also spoke with two health care professionals who visited the home during the inspection. We spent time observing the interaction between people who lived at the home, relatives and staff. 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.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for five people, handover records, the accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans. Following the inspection we spoke with one health / social care professional.

Good

Is the service safe?

Our findings

The provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse (SOVA). The registered manager explained how they used the local authority safeguarding procedures and any concerns were assessed using the threshold tool. A decision was then made following discussions with the local safeguarding team regarding whether an alerter needed to be submitted. The home was able to show how they submitted alerters in respect of any concerns and had also notified the CQC as required. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

The staff we spoke with confirmed they had completed safeguarding training and could describe the different types of abuse, what signs to look for and the actions they would take should they become aware of poor practice or witness any abuse. Staff explained how they would take action to protect people at risk by reporting concerns to their line manager or by "blowing the whistle" regarding any unacceptable practice that was not challenged. One member of care staff told us "I would report any abuse to the senior, the manager or the regional manager, but I've not needed to." Staff told us that they had confidence in their colleagues to report anything of concern and also told us that they had never observed any practice which caused them concern. The homes training records showed us that 93% of staff had completed safeguarding training.

We looked at people's care plans and saw the home had individual assessments in place for risks such as falls, pressure care, nutritional intake and weight loss. We saw that these were reviewed and updated regularly so that any changes in risk or a person's needs could be recorded. The staff we spoke with told us that risks were recorded in people's care plans and gave examples of some of the risks they had identified; for example, people who expressed distressed behaviour. Staff were able to tell us how they would try to minimise these risks; for example, approaching people in a calm and gentle manner or by allowing time for a person's behaviour to de-escalate before attempting to provide them with assistance.

We looked at the homes incident and accidents logs and found that any incidents or accidents were well documented describing what had happened, where it had happened, who was involved and the response provided by staff. We saw that these were analysed each month so that the registered manager could identify any reoccurring issues and also to ensure that where a person had fallen repeatedly proper action was taken. We also saw that action plans were put in place to ensure that people were appropriately monitored following a fall or when they had sustained an injury. We noted the home used these records as an opportunity to learn and saw that recommendations were made to try and reduce the likelihood of the incident being repeated.

We looked at maintenance records and safety checks which were carried out to reduce the risks in the environment. This included checks on the fire alarm, emergency lights, call bells, lifts and water temperatures. We saw maintenance records for gas safety, electrical safety, legionella, fire and portable appliance testing. These checks helped to ensure that the building was maintained safely. We were told by a member of staff that only one hoist was working on the day of the inspection. This meant that staff had to share the hoist across the two sides of the home resulting in a delay should people require moving. This issue was addressed with the provider who explained they have an equipment store to ensure when equipment was deemed unsafe or faulty it could be replaced quickly. Had they been made aware that the hoist was faulty it would have been replaced whilst it was awaiting repair to minimise impact on people living in the home.

The homes manager told us that they determined the number of staff required for each shift based on the needs of the people they were caring for. Pre-admission assessments were completed to assess the needs of the person and to help the registered manager make a decision on whether the home could effectively meet the person's needs. We looked at staff rotas and saw that the appropriate number of staff as calculated by the provider were allocated to each shift.

We spoke with a member of care staff and they told us that they did not feel there was always enough staff. They told us as that the senior care workers were very busy completing paperwork and as a result spent 90% of their time in the office. They also told us that staff sickness was not always covered if it was at short notice. We were told this could happen two to three times per month and meant

Good

Is the service safe?

that staff did not always have time to support people as quickly as they would like to. Another member of staff said "We're not short staffed usually, but struggle when staff are sick."

We spoke with two people who lived in the home; they both said that they felt there were enough staff and that they were nice. When asked about staffing levels one relative told us "I have no concerns, there's enough staff, my mother's needs are met and they get to go out on activities." Another relative who was visiting the home told us "Yes there's enough staff, they always attend quickly." Whilst we were in the home a member of staff found that one person was on the floor in their bedroom and they pressed the call button to summon assistance. We saw that two members of staff quickly responded and were able to provide support within less than two minutes.

We looked at the recruitment records for the two most recent members of staff. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home, including a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

We looked at medication policies, procedures and systems and found that medication was ordered and stored correctly across both units of the home. We saw that the medication trolleys were stored in the medication room and were securely fixed to the wall to ensure medicines were safely stored. There was a dedicated medications fridge and we saw that temperatures had been recorded to ensure that the medications were stored according to guidelines.

We checked the storage and recording of controlled drugs (CD's) and saw that this was satisfactory. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs legislation. We checked a random sample of CD's and saw that the balance of medicines corresponded to the records in the CD register. We saw that these were signed and counter signed in the CD book and the medication administration record (MAR) chart to ensure administration of CD's was accurately recorded. MAR charts are the formal record of administration of medicine within a care setting and may be required to be used as evidence in clinical investigations and court cases. It is therefore important that they are clear, accurate and up to date.

We looked at the MAR charts across both units. We saw that these included a picture of both the person and the tablet or medication. The times medicines needed to be administered were also colour coded to match the colour on the blister pack that the medications were provided in. This helped ensure that the right person was receiving the right medication at the right time. We saw that the MAR charts were up to date and accurately completed.

When we last inspected we saw that there was no protocol in place to record the administration of 'as and when required' (PRN) medication. We saw that care plans now explained when and why PRN medication should be given. We also saw that administration of PRN was recorded on peoples MAR charts. However, the reason for administration of PRN should be clearly recorded in a person's care plan each time it was given. We saw no records to verify this. We also saw that PRN medication was offered routinely at the same time every day. If PRN medication is required at the same time each day then a medication review should be requested. We saw no records to confirm this had been asked for.

We recommend the service ensures that current guidelines are followed in relation to the administration of PRN medication.

On both days of the inspection we saw that the home was clean tidy and free from any unpleasant odour. We saw the home had daily and deep cleaning schedules in place and these were completed by the homes domestic staff. One relative told us "the home is always clean and tidy when I visit."

Requires improvement

Is the service effective?

Our findings

The staff we spoke with told us that some of the people who lived in the home could display both verbal and physical behaviour that might challenge others. One member of staff told us that they had been hit by a person living in the home. We saw that this issue was also raised through the homes staff survey where staff requested more support when facing challenges in the home. When asked if they had received any training to manage these types of behaviours staff told us they had not. We looked at the homes training records and saw that although staff had completed dementia awareness training; this did not include techniques to physically manage behaviour such as low level holds and break away techniques.

The staff team and registered manager all told us that restraint is not used within the home. However some staff told us that they sometimes need to hold peoples arms to protect themselves whilst they retreat from a room to allow the person to calm down as described in the persons care plan. Although this physical intervention is only brief and uses the minimal amount of force the registered manager needs to ensure that staff have received the appropriate training to minimise risk to both the person they are caring for and themselves.

The registered manager acknowledged that this was an area of training that needed addressing as the needs of the people who were now admitted to the home were much higher than in the past. They told us that they were constantly reviewing which training the staff team required to ensure they could meet the needs of the people they cared for and they were hoping to implement this training soon.

This was a breach of Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

All new staff completed a three day induction and then completed a week of induction shifts within the home where they were supernumerary to the staff on duty. This provided them with an opportunity to watch more experienced staff perform their day to day care routines and familiarise themselves with the expectations of the home. Staff were issued with an induction workbook which was started during the initial three day induction and had to be completed within 12 weeks. On completion the staff were issued with the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

One member of staff told us "There is a standard induction, you cover all the mandatory training such as moving and handling, fire safety and safeguarding but I'm not sure if everyone gets all the training before they start. You only get four induction shifts." We looked at staff induction booklets and saw that these were all completed; however one was not dated which made it difficult to know whether they had completed relevant training before starting on shift. We discussed this with the registered manager who informed us that the training had taken place; however it had not yet been signed off.

The eleven senior care staff had completed training on the administration of medication, although we saw that refresher training was overdue. One person had completed this training in 2005, one in 2007 and two people had completed the training in 2010. However the registered manager told us that they completed competency checks and also medication audits to ensure that medication was administered safely; our observations supported this.

We saw the home kept records of any training the staff team had completed and that these records were used to ensure that staff keep up to date with training. We saw that staff had access to a range of training that the registered provider deemed essential. The training was provided by ERYC and the providers own in-house training company and included face to face sessions and distance learning packages. Staff told us they completed training such as fire safety, moving and handling, infection control, safeguarding, dementia awareness and health and safety. Records showed that almost all staff had completed this training or were booked onto a refresher course. Training records also showed us that all members of care staff had either achieved or were working towards a National Vocational Qualification (NVQ) at Level 2 or Level 3. We saw that a number of staff had already attained Level 3 with the registered manager qualified to NVQ Level 5.

However staff had not received training in how to effectively manage people with behaviours that may challenge. This meant that staff did not have all the necessary skills to effectively carry out their role.

Requires improvement

Is the service effective?

We saw that staff supervisions were completed and staff told us that they received 'supervision' every two months. These are meetings that take place between a member of staff and a more senior member of staff or manager to give them the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. One member of staff stated these meetings were quite brief. However all staff we spoke with apart from one told us they were well supported by the registered manager.

The Care Quality Commission is required by law to monitor the use of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected and is vital in ensuring people receive person centred care. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control.

We saw that the registered manager and the senior care workers had completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and following a discussion with the registered manager it was clear they understood the principles of the MCA and also when it would be appropriate to submit a DoLS authorisation form to the local authority. CQC had received notifications to confirm when a DoLS application had been authorised for a person using the service.

We asked staff about their understanding of the MCA. One staff member told us "It's just whether a person is deemed to have capacity to make their own decisions. If they can't we speak to family or get an advocate." Another said "It's whether they have the competency to make decision." Staff told us they made some decisions for people who lacked the capacity to consent to care on a daily basis. An example of this was when people were unable to effectively communicate whether they would like to get up and dressed in the morning or remain in bed. Staff would offer encouragement to get them up and ready for breakfast unless the care plans advised them differently.

We saw that the staff sought consent from people in respect of the content of their care plan, the sharing of information and also for the home to be able to take photographs of them. We saw that where the person was assessed to lack capacity the home would sometimes consult with a family member and ask them to sign the consent forms. On other occasions we saw that a member of staff sometimes signed to acknowledge a person's consent.

When a person lacks the capacity to consent to the plan of care a best interest meeting should be held to ensure the persons care is delivered in a manner they would be happy with. We also saw that one person was having their medication administered covertly. This is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. There was a note on file stating this had been agreed with the GP and the family; however there was no mental capacity assessment or best interest paperwork present to support this decision. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

This meant that although the registered manager had consulted people using the best interest process, this had not been formally documented utilising the best interest paperwork.

We recommend that the registered manager ensure they fully follow current guidelines in relation to best interest decisions.

We saw that some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation in their care files. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. We saw that these were completed correctly although one provided conflicting information and required reviewing. This was fed back to the registered manager on the day of the inspection and they informed us they would ensure that this was followed up with the GP.

We observed both breakfast and lunchtime in both sides of the home. We saw that there was enough staff present to ensure that those who required assistance with eating and drinking were provided with this in a dignified manner. We observed staff assisting one person to eat their breakfast;

Is the service effective?

the staff member spoke to the person throughout and allowed them to dictate the speed at which they ate their food. We saw that some people used specific equipment which enabled them to continue to eat independently.

We saw that people were given a choice of two main meals and two desserts. One person told us "You get well fed and have a choice of food." Another said "You have a choice of two meals which you decide the day before, the food is good overall." A visiting relative told us "The food always looks lovely." A member of staff told us the food was always served at the right temperature and we observed staff using a probe to check that the food was hot. However, we saw that although there was a menu board in place it had not been filled in on the day of the inspection. This meant that people did not have a visual reminder of what meal was planned for that day.

We saw that people were weighed on a regular basis and that the home used the Malnutrition Universal Screening Tool (MUST) to assess people's nutritional needs and determine whether any recorded weight change was regarded as significant. Those people who were deemed to be nutritionally at risk were referred to a dietitian to have their nutritional requirements fully assessed. We saw that the home used food and fluid charts to help keep a record of people's daily consumption.

However we saw that the recording of these charts was not always accurately completed making it difficult to determine what quantities of food and fluids people had actually consumed. One member of staff told us that not all staff recorded when fluids had been offered and declined by the person. This meant that it was more difficult to accurately determine whether people's nutritional needs were being met, increasing the risk of people suffering dehydration and weight loss

We recommend that the home ensures guidance on the accurate completion of food and fluid charts is implemented and all charting is thoroughly audited.

We saw that people's healthcare needs were mostly met. People were able to talk to health care professionals about their care and treatment and referrals were made to the relevant professional should the need arise. We saw evidence that individuals had input from their GP's, district nurses, chiropodist, opticians and dentists. All visits or contacts were recorded in the person's care plan with the outcome for the person and any action taken if required in relation to their specific health . This included the date the advice received from health care professionals had been incorporated into care plans. However we saw that people receiving PRN medication did not always have this reviewed as regularly as they needed to.

We saw assessments had been used to identify the person's level of risk. These included those for pressure care, tissue viability and nutrition. Where risks had been identified, risk assessments had been completed. These contained detailed information for staff on how the risk could be reduced or minimised. We saw that risk assessments were reviewed monthly and updated to reflect changes where this was required.

We saw that those people assessed to be at risk of developing pressure sores had plans in place to minimise this risk. We saw that some people were required to be repositioned within specific time frames to alleviate pressure and these people had 'repositioning charts' in place. Repositioning charts should state how often a person needs to be repositioned and also record the times when repositioning has actually taken place. We saw that although the home had these charts in place, some of them had been completed retrospectively. It is important that charting is completed at a time as close as possible to when the care was provided or the observation was made as this provides the most accurate information.

The registered manager told us that none of the people living in the home had a pressure sore at the time of the inspection.

We spoke with a community staff nurse who was visiting the home on the day of the inspections. They told us they visit on an almost daily basis to provide insulin injections, wound dressings and palliative care. They told us "The home is lovely, staff are very supportive and call or fax immediately if there are any concerns." They also commented "The staff follow any instructions and guidelines given."

Some areas of the home had been designed for people with dementia related needs and these areas had undergone a process of refurbishment that was almost complete. This had seen the home benefit from the addition of four new rooms, new flooring, new furniture in the lounge and dining room and a new bathroom which was in the process of being completed. The home was decorated to a high standard and it was clear efforts had

Requires improvement

Is the service effective?

been made to ensure that areas of the home were more dementia friendly with the introduction of coloured doors, different coloured toilet seats and hand rails helping to orientate people who may be confused.

Good

Is the service caring?

Our findings

All of the people we spoke with told us that the staff were kind and caring. One person told us "The staff are kind, they are all nice." Another said "Staff do their best; you can always get help to go the bathroom if you need it." People looked clean, their hair was tidy, they were appropriately dressed and they looked well cared for.

We carried out a Short Observational Framework for Inspection (SOFI) in the main lounge; this is a way of observing care to help us understand the experience of people who could not talk with us. The SOFI observation highlighted a number of positive interactions between members of care staff and the people living in the home. We saw staff offering reassurance and encouragement to one person saying "That's brilliant, well done" whilst assisting them to move out of the lounge. We also saw that staff made the time to stop and ask if people were alright. We saw that staff knew when to use touch, eye contact and gestures to enable them to effectively communicate with people.

We saw that staff knew the people they cared for very well. Staff were seen to manage different scenarios and approach each individual in a manner that was responsive to their individual needs. For example we observed one person who became quite distressed midway through the afternoon. We saw that staff knew how to best respond to the person and were quick to distract and offer reassurance to help alleviate their distress. This showed that staff understood how to respond to people's individual needs in a caring and effective way.

Staff showed genuine concern for the people they cared for. They spoke to them in a respectful manner, told them what was going to happen before carrying out any care tasks, asked if they were happy to receive the assistance and then talked the person through each stage of the task as it happened. Staff commented that whilst they felt the needs of people were met, they would like to spend more 'quality time' with each person talking to them and finding out more about their lives. One member of staff told us "I treat the residents like I would my own grandparents."

We saw that the home promoted peoples independence. People were free to move around the home as they pleased even when this may increase the risk of a person experiencing a fall. One member of staff told us "Sometimes people fall, but they are the ones who enjoy walking." Another staff member told us "A lot of the residents use incontinence aids, but we always encourage them to try and go to toilet to maintain their dignity."

People were given choice about how their care was delivered. We saw that people were able to choose when they wanted to go to bed and when they got up. Staff told us that some people liked to stay up all night; however they encouraged them to go to bed to ensure they were getting enough rest. Staff explained people could have a bath whenever they wanted, but they kept a record of when people had been assisted to have a bath to ensure they could check that people maintained their personal hygiene. We were told that one of the bathrooms had been out of action for nearly four weeks.

When we spoke to the provider they told us that the bathroom had been fully renovated and was almost complete. They stated that other bathing facilities had been available during this period. They acknowledged this had taken longer than expected yet hoped that it would be worth the wait due the quality of the bathing facilities the people living in the home would now benefit from.

We observed that staff respected the privacy and dignity of the people they cared for. We saw that staff knocked on peoples doors before entering and we also observed staff transferring a person using a hoist. We saw that the staff placed a blanket over the person's legs whilst they were been transferred from a wheelchair to a chair in the lounge ensuring that the persons dignity was maintained.

We saw that people's relatives were able to visit whenever they wanted and they told us that they were made to feel welcome by the home. The relatives we spoke to told us that staff knew what people's needs were, that they were approachable if they needed anything and that they always contacted them if there were any problems.

Good

Is the service responsive?

Our findings

We looked at the care plans of people who used the service. We saw that each person had undergone a preadmission assessment to help the registered manager determine whether the home was able to meet the needs of the person before admitting them. We found care plans to be well organised, easy to follow and person centred. They described in detail a person's needs and how the home planned to meet these needs whilst also promoting their independence. They included information relating to people's family history, their likes and dislikes and any hobbies they were interested in. This told us that the person, their friends, family or advocate were consulted during the development of the care plan.

We saw that care plans were reviewed by the home on a regular basis to ensure that the information remained reflective of the person's current level of need. We also saw evidence that reviews took place with family and a social care representative present.

We spoke with both the care staff and management who told us that recording of daily dairies, food charts and in some cases turn charts took place at the end of a shift as this is when staff had time to record information. We spoke to the registered manager and she acknowledged that the recording of peoples care could be improved although they were confident that peoples care was delivered according to the persons care plan. They assured us that this would be addressed with staff.

Prior to the inspection we received information of concern in respect of people being assisted to get ready for bed as early as 5.00 pm for the convenience of staff. When we visited the home on 11 August 2015 we arrived at 7.00 pm so we were able to check the number of people who were in bed at that time. On arrival we found that there were 19 people in the lounge on the dementia side of the home and we saw only two of them were in their night clothes. The people we spoke with across both sides of the home told us they went to bed when they chose to.

The home employed three activity coordinators who worked across the home on six days per week. They provided a range of activities specifically targeted at the different people they supported. We saw that the home has an activity diary and this included activities such as keep fit, bingo, quizzes, trips out and a weekly news morning. We saw that a televised church service was played in the home on a Sunday and that the home received a visit form the church on a monthly basis. One member of staff told us that people had been enjoying the new outdoor space that had been developed by the home. This was a safe and secure space which provided people using the service with an opportunity to freely access the outdoors and sit and relax or provided an additional area to explore for people who liked to be constantly on the move.

During the inspection we saw that people's friends and relatives were free to visit at any time during the day. Some visitors chose to spend time in the home with their friend or relative, whilst others liked to take them out for lunch or a drive out in the car. This enabled people to maintain relationships with people who did not live in the home.

We saw that there was a complaints procedure in place and that this was followed by the registered manager, with all complaints been fully investigated. People we spoke with knew how to make a complaint and staff told us they were aware of how to support people to make a complaint if they were unhappy with the care they were receiving, but mentioned they rarely had any complaints. We spoke to a visiting social service's professional and they told us "I have had complaints about here; however the manager always follows these up ensuring that any action required is taken. She is very approachable, listens to concerns and responds accordingly. She has made some remarkable changes since her arrival."

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since1 August 2013.

We saw the home had a system in place to continually audit the quality of the care provided by the home. We saw that audits were carried out each month to monitor all occurrences at the home, including incidents, accidents, falls, deaths, safeguarding incidents and notifications to CQC. We saw that these had been completed in line with the homes policies.

We saw that the registered manager checked ten care plans per month to ensure that the information they contained was up to date and reflective of the person current level of need. We saw that where any issues were identified that plans were put in place to address them. This helped ensure that care plans gave the most up to date guidance on people's needs.

Staff files were also audited to ensure they contained the correct information in relation to recruitment and to ensure that all training records are well maintained. This enabled the registered manager to monitor the training needs of individual staff to keep them up to date with both mandatory and non-mandatory training and also to track their progress on the NVQ's they were completing. Staff told us that as an incentive to complete their NVQ Level 2 they received a small increase in their wages on completion. We also saw that staff files including a job description, this ensured that staff were aware of what was expected of them in their specific role.

We saw that medication audits took place with the most recent occurring in July 2015. The audit identified that some signatures were missing from the MAR charts and this enabled the manager to address this through staff supervisions.

The home carried out surveys with the people living in the home, the staff and also relatives to help improve the service that they delivered. One member of staff told us "The manager is approachable; however you don't always get feedback. We completed a staff survey but have not had any feedback yet." The registered manager provided us with a copy of the staff survey which highlighted a number of issues for the service to address. They told us they would make sure the analysis of the survey was fed back to staff.

One member of care staff told us "If I had a major concern I would approach the manager." When asked if they ever had reason to, they confirmed they had spoken with the manager regarding staffing levels in the home. They told us "The home is now interviewing for new staff and I've noticed on the rota's we are getting a split shift so there is an extra pair of hands during busy periods." Another said "I find the manager approachable, she always listens and I can raise concerns."

The manager was able to empathise with those staff members who stated they felt that they were sometimes short on numbers when people called in sick. The home had recognised that ensuring the right numbers of staff were always available was a challenge; the registered manager and provider told us that they were continually advertising for new staff to increase the size of the pool of staff that they had access to. The provider informed us that they had two new members of care staff who were due to join the team imminently and that this would enable the home to not only ensure that cover was always available, but to have an extra member of staff per shift. It was hoped that this would help ensure staff had time to both perform the required care tasks whilst also having an opportunity to spend more time with the people who lived in the home.

We saw that the home held regular staff meetings, and the staff we spoke with told us they attended these when they could. We saw that these meetings were used to address any issues within the staff team and explored ways of improving the way the home operated. We saw that one member of staff had stated that they felt communication could be improved between the different shifts and the home had responded by implementing a new communications log to ensure that key information was passed on to the next team.

We saw that the registered manager operated an open door policy and that people living in the home often entered the registered manager's office for a chat, a cup of tea and a biscuit. People we spoke to told us that the registered manager was approachable. We spoke to a visiting social care professional and they told us "The manager has made some remarkable changes since her arrival. She is very approachable, listens to concerns and responds accordingly."

Good

Is the service well-led?

We saw that notifications were submitted to the Care Quality Commission as required. These are forms which enable the registered manager to tell us about certain events, changes or incidents.

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 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity were not receiving such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).