Cherry Garden Properties Limited

Castle House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 and 31 March 2016 and was unannounced. Castle House is registered to provide personal care for up to 33 people. They provide care and support for frail older people and those people living with dementia. On the first day of our visit there were 16 people living at the service which included two people receiving respite support. On the second day of our visit another person had come to the home for a short stay, making 17 people at the service.

We carried out an unannounced comprehensive inspection of this service on 15 and 18 December 2014. Breaches of legal requirements were found. We returned on 30 April 2015 and undertook a focussed inspection to check whether requirements had been met. CQC took enforcement action because improvements were needed in relation to staffing arrangements and the Mental Capacity Act 2005. We therefore undertook a further focused inspection on 17 September 2015 to confirm that they now met legal requirements in relation to the warning notices. We found that although issues highlighted in the warning notices had been addressed, there were still areas of improvement needed. An issue was identified in respect of people not being protected against the risks associated with unsafe or unsuitable equipment. This was because there was no record of what staff should check to ensure the equipment was being used properly and it had not been regularly maintained. We found this had been addressed by this inspection.

In July 2015 the provider had made changes to their registration with the Care Quality Commission and had removed two regulated activities which meant they were no longer providing placements for people with on-going nursing needs. People living at Castle House were now under a residential service contract and any nursing needs were being met by the community nurse team. Care staff had received training to take over some roles previously completed by nurses.

The service had an advisory placement suspension in place with the local authority. This meant that all new admissions into the home had to be agreed by the local authority health and social care cluster manager on a case by case basis. The registered manager was also working with the local rapid intervention team and had been taking people who required respite support. They were also working with the local authority quality assurance and improvement team to develop and progress their improvement plan.

When we visited there was a registered manager in post. The registered manager had started working at the home in June 2015. They became registered with the Care Quality Commission (CQC) in January 2016. A registered manager is a person who has registered with CQC 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 registered manager was very visible at the service and undertook an active role. They were very committed to providing a good service for people in their care and demonstrated a strong supportive approach to staff. Since this inspection, the registered manager has left and the service is recruiting for a new registered manager.

The premises and equipment were not always managed to keep people safe. Fire checks had not identified blocked fire exits and fire doors which did not close fully.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. All care staff had undertaken or were enrolled on recognised national qualifications in health and social care. Staff had been developing skills and knowledge to meet people's needs. There were adequate staffing levels to meet people's needs.

People felt safe and staff had a good understanding of what constituted abuse and how to report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were not always safely managed on people's behalf.
Care plans had been re written in a new format. They were personalised and recognised people's social and psychological needs. However they still lacked detail regarding people's health needs. People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

The registered manager and staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

People were supported to eat and drink enough and maintained a balanced diet. The registered manager had been working closely with people and staff to provide a menu that all people at the service would be happy with. Staff relationships with people were strong, caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate.
Staff supported people to follow their interests and take part in social activities. A designated activity person was employed by the provider and supported people at the service to take part in activities.

The culture of the home was open, friendly and welcoming. The registered manager had developed clear leadership and was delegating staff roles and responsibilities. The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. However they had not identified the areas we identified in relation to fire safety or medicines. Where there were concerns or complaints, these were investigated and positive action taken.

We identified three breaches of regulation at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some areas of the service were not safe.

Improvements were needed in respect of how medicines were being managed.

The premises and equipment were not always managed to keep people safe. Fire checks had not identified blocked fire exits and fire doors which did not close fully.

People said they felt safe and staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

The registered manager ensured staff levels were adequate to meet people's individual needs.

There were effective recruitment and selection processes in place.

Is the service effective?

Good

The service was effective.

Staff received training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through contact with community health professionals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Visitors were encouraged and always given a warm welcome.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans had been re written for people. They were person centred about people's histories, wishes and social need. However they did not reflect people's health needs and guide staff how to appropriately meet their needs.

The staff team were working towards making people's health needs care plan information more personalised. Staff knew people's preferred routines.

A designated activity person supported people to undertake a range of activities.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were measures in place to assess the quality and safety of the service people received. However these did not always identify areas of concern.

The provider had displayed their CQC rating in the main entrance to the home. However they had not displayed their rating on their website.

Staff spoke positively about communication and how the registered manager worked well with them.

People's views and suggestions were taken into account to improve the service.

Castle House

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 was 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.

Castle House is registered to provide personal care for up to 33 people. They provide care and support for frail older people and those people living with dementia.

This inspection took place on 24 and 31 March 2016 and was unannounced. One adult social care inspector completed the inspection.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which we received in December 2015. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

We met and observed most of the people who lived at the service and received feedback from seven people who were able to tell us about their experiences. A few people using the service were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to help us understand their experiences. These methods included informal observation throughout the inspection. We also spoke with a visitor and a visiting hairdresser to ask their views about the service.

We spoke and sought feedback from 14 staff, including the head of care, senior carers, catering staff, the maintenance person and administrator. We also spoke with the registered manager and the responsible individual referred to at the service as the operations manager.

We reviewed information about people's care and how the service was managed. These included three people's care records and seven people's medicine records, along with other records relating to the

management of the service. These included staff training, support and employment records, quality assurance audits, minutes of team meetings and findings from questionnaires that the provider had sent to people. At the inspection we spoke with a visiting district nurses. We also contacted the quality assurance and improvement team manager and health and social care professionals and commissioners of the service for their views. We received a response from four of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and supported by staff. One person commented, "Oh yes I feel safe here, I would soon have something to say if I didn't."

The environment was not always safe for people who used the service, visitors and staff. This was because there were not always effective fire and risk assessments undertaken to keep them safe. One fire exit door was blocked by a person's personal possessions and a portable radiator. Another fire exit door which was known by staff to swell when damp was very difficult to open. It was also restricted from opening by foam lagging around the pipes on the outside of the building. There were also three internal fire doors which were not able to be closed fully. Two because the automatic door closures were not working correctly. The third because a person had placed a possession to keep their bedroom door slightly ajar. There was no documentation to demonstrate this had been discussed with the person or risk assessed to minimise the risk to them. Although there was a fire checks carried out weekly in accordance with fire regulations. This demonstrated that the checks undertaken were not effective in identifying fire risks. We have contacted the local fire service who have scheduled a visit to the home to undertake a review.

The responsible individual made us aware that they were having difficulties with their heating system at the home, meaning some radiators did not work. Work had been undertaken to resolve the problems and been unsuccessful. At the time of the inspection they were awaiting another company to visit to assess the heating system. In order for people not to get cold, portable radiators were in use. These had been placed in the main lounge and throughout the home in people's rooms. Radiators are likely to operate at temperatures which may present a burn risk and may be a trip hazard. However there had been no risk assessment of the premises undertaken to identify what controls were necessary to protect people as recommended by the Health and Safety Executive. Risk assessments for individual people had not been undertaken considering the potential risk of burning from the radiators. Staff were recording daily the temperature in people's rooms but there was not guidance to advise them what to do if they found the rooms too hot or too cold. The room temperatures were not monitored by senior staff to ensure people were not at risk of being supported in an environment which was unsuitable. Therefore the provider had not taken reasonably action to mitigate risks to people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

The registered manager said they had an on-going programme of redecoration underway to improve the environment of the home. The provider employed a full time maintenance person who oversaw maintenance at the service. They undertook regular checks and maintenance of equipment. These included monthly checks of the emergency lighting, wheelchairs, window restrictors and water temperatures. A person confirmed that the checks were undertaken in their room. They commented, "They come in most weeks to check the water." The maintenance person also checked fire extinguishers had not been tampered with. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, gas, electrical and lift maintenance. Fire drills were carried out weekly in accordance with fire

regulations. A fire safety consultant had undertaken a fire risk assessment in February 2016 for the provider. They had made recommendations of areas which would not be effective in the event of a fire. The responsible individual and maintenance person were still working to address some of the issues identified. However there was no clear action plan to ensure all risks were managed. The responsible individual said they had an external person quote to undertake the bigger jobs and the maintenance man had started work on the smaller jobs.

Management of medicines was not always safe. There was no clear system to ensure people had their topical creams administered as prescribed. Prescribed creams were recorded on people's medicine administration records (MAR). In most cases with the exception of two people's prescribed creams, a topical cream chart with a body map had also been put into place. This guided staff which cream to use, where it should be applied and the frequency of the cream application. Some staff had signed the MAR and others had signed the topical cream chart. However there were still significant gaps in the administration of people's creams. The registered manager had recognised this was an area of concern and raised it with the staff at a staff meeting held while we were undertaking our visit. One staff member said, "We do the baths and the creams but forget to record them, this will improve." Two people's prescribed topical creams were located in the communal bathroom which had not ensured they were stored safely and readily accessible to the people they were prescribed for.

Where people had medicines prescribed, as needed, (known as PRN), some but not all had protocols in place about when they should be used. This meant that staff might not be aware of why and when they should administer these medicines to people appropriately.

Some medicines are required to be recorded in a register when at the home. We found one person's medicines which had not been entered into this register. However action was taken immediately to record these medicines when we identified the problem.

Medicine administration records (MAR) were well completed with no missed signatures to demonstrate administration. However when staff recorded hand written entries on the MAR chart for new medicines; they had not signed their entries. Also they had not had a second person check their entries which is good practice. By the second day of our visit improvements had been made. A new person who had come into the home had a handwritten MAR chart which had been signed and checked by the staff members completing the entry.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis. When the home received the medicines from the pharmacy they had been checked in and the amount of stock documented to ensure accuracy. Medicines were kept safely in a locked medicine cupboard. The cupboard was kept in an orderly way to reduce the possibility of mistakes happening. A pharmacist had visited the service in February 2016 and completed a medicine's check. They had raised no significant concerns regarding the management of people's medicines at the service. Where they had made recommendations the registered manager had taken action to address them. For example, they had recommended an updated list of staff who could administer medicines and that the temperature of the room and cupboard where medicines were stored were monitored.

Staff recorded required repairs and faulty equipment in a maintenance file and these were dealt with and

signed as completed by the maintenance person. However staff were not always recording their concerns and were passing them verbally to the maintenance person. This did not ensure there was a clear audit trail of the staff identifying concerns and the necessary work being carried out. We identified that there was a broken pane of glass in one bedroom, a sash window broken in another and a light not working in a corridor. However there was no record these concerns had been identified.

The registered manager who was a trained manual handler trainer confirmed they had adequate equipment available to meet people's needs. They said, "We have excellent equipment, two hoists, a stand aid and a turner every resident has their own sling and wheelchair if they are required." There was also manual handling guidance in people's rooms to guide staff about the correct way to assist the person to move and the equipment required. For example, type of hoist, sling and slide sheet.

People were protected because health and falls risks for each person were identified and managed. Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional risk, pressure damage and falls risk. Improvements had been made with regards pressure relieving equipment being used at the service which had been identified as a requirement at our last inspection. People had clear skin integrity risk assessments undertaken and appropriate equipment in place to meet their needs, for example pressure relieving mattresses. Staff were guided about which equipment people had in place and the appropriate settings the mattresses should be set on.

A legionella assessment had been undertaken in February 2016 and stated no remedial action required with some recommendations. This report had arrived just prior to our inspection and the recommendations had not yet been actioned.

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission (CQC).

The registered manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis.

There were effective recruitment and selection processes in place to ensure fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken and any employment gaps had been explored. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff were busy but had time to meet people's individual needs. People and staff said they felt there were adequate staff levels to meet their needs. People when asked said, "Only just enough, I manage myself, the others are not so able."; " Good I would have thought there always seem enough staff, I don't use my bell so can't comment on how quickly they respond.": "There are four care staff in the morning and three in the afternoon and two or three at night. We ring our bells and they will cough up a mug of tea in the night if we ring, they are very good indeed." Staff said they felt when the full

complement of staff were on duty there were enough staff and that people were safe. One commented, "There are not always enough staff in the morning which makes it difficult we should have a senior and three carers then it is alright."

The registered manager used a dependency tool to identify required staffing levels based on people's individual needs. They said "I wouldn't take more than two people a week. I complete the dependency tool purely to gauge what residents ability is. I continually oversee the resident occupancy to ensure staffing cover is arranged. I don't like to use agency but will if absolutely necessary." They had followed advice from the local district nurse manager and had changed the allocation of their care staff ensuring there was a senior carer and two carers on duty each afternoon. They had previously had four care staff in the morning and one on in the afternoon with a senior carer. The staff schedule from 14 March 2016 to 3 April 2016 showed on nine days there were three care staff and a senior carer on the morning shifts, two care staff and a senior carer on the afternoon shift and two care staff at night. On the other 12 days there were two care staff and a senior carer on the morning shifts. These were supported by a cook, a kitchen assistant, housekeeping staff an activity person, an administrator and a maintenance person. The registered manager said they were working to scheduling three carers and a senior carer each morning.

The registered manager was actively recruiting to fill vacancies in the staff team. They had two new staff undertaking an induction and also made us aware that they had two apprentices joining the team. The staff and registered manager undertook additional shifts when necessary and agency staff had been used to ensure adequate staffing levels were maintained.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service. People's individual peeps were held in their care records. There was also a grab folder which contained everybody's PEEP's with the exception of a new person who had recently come to the service. The registered manager addressed this during the inspection. The provider had arrangement with two local providers to use their premises in the event of needing to evacuate Castle House. This showed the home had plans and procedures in place to safely deal with emergencies.

Accidents and incidents were reported. For example, staff had recorded in the accident book and on an incident form. That a person had fallen out of bed and as a result had arranged for the person to see their GP for a health check and an assessment was undertaken to consider bed rails. This was reviewed by the registered manager to identify ways to reduce risks as much as possible.

The registered manager said they were also developing a fall chart. This was a plan of the building and when an incident occurred a pin would be used to mark the location. They said the plan would identify if there was a pattern of where people had fallen. However they went on to say and records confirmed there had not been a high level of falls at the home.

Good

Is the service effective?

Our findings

People's needs were met by staff who had the right competencies, knowledge and qualifications. The registered manager had recognised staff training as a priority when they started at the service. This was because previously the service was registered to provide nursing care and care staff worked with registered nurses who took overall responsibility. The registered manager said, "We have had to upscale all staff as before the carers were being led by the nurses and didn't have the necessary skills." The registered manager had delivered some training including manual handling and had been working with the local nurse educator and local training providers. Training undertaken included, infection control, influenza and pneumonia, pressure prevention, diabetic training, common illnesses, continence care, recognising urine infections, completing fluid charts, dementia and care planning. The registered manager said they were going to deliver handover training as they had recognised this was an area which needed developing.

Some staff had not attended some of the training provided. The registered manager said letters were being sent out to staff to make them aware that if they had not undertaken training within a certain time frame they would not be allocated any shifts until completed. However all care staff had or were working towards a higher qualification in health care. Kitchen staff had been enrolled onto recognised training courses in kitchen management. The registered manager had also enrolled on a level five leadership and management course. This demonstrated that the registered manager was committed to improving staff knowledge.

Staff were positive about the training they had received. Staff comments included, "We have just done training for dementia, urine infections with the nurse educator."; "The training we have had has helped a lot, some of the staff were shocked what can happen and the dangers."; "The training is good, definitely helps." One person confirmed they felt staff were well trained. Their comments included, "They are very good they know what they are doing some have worked here for years and live locally."

Staff had undergone an induction. The majority of staff said they felt the induction had given them the skills to carry out their roles and responsibilities effectively. The registered manager had introduced and was working with staff to complete the new Care Certificate which had been introduced in April 2015 as national training in best practice. The registered manager said, "If experienced in care, they only do a few shadow shifts otherwise a week and a half. They have to do a manual handling practical before they can be officially counted. I schedule new staff on the afternoon shifts as they are quieter." The registered manager and a staff member were trained to deliver manual handling training to new staff. There was training scheduled for a staff member who had started at the service the week before our visit. This ensured staff were competent and effective in assisting people to safely move and transfer if assistance was required.

The registered manager said they recognised the importance of staff supervisions and she had met with all staff to undertake supervision since starting at the service. Where staff had required additional support and performance management they had received more supervisions. They said their aim was for staff to have a supervision three times a year and an annual appraisal. A program of appraisals were scheduled to be undertaken in April 2016, staff were made aware of the process at the staff meeting we observed.

People's consent for day to day care and treatment was sought. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and found they were.

The registered manager confirmed staff at the service had undertaken basic training in MCA 2005 with further training scheduled. They had also been allocated a booklet regarding the principles of the mental capacity act to carry in their pockets. The registered manager said they were happy they could contact the local authority DoLS team for guidance when required.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's liberty was restricted as little as possible for their safety and well-being. For example, a careful assessment was undertaken whenever the use of bedrails was considered for the person's safety.

The registered manager confirmed three DoLS applications had been submitted and were awaiting assessment. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. A district nurse attended the service each day to administer insulin to people with diabetes. A visiting district nurse said, "If staff have a concern they will instantly let us know. They are all lovely and friendly, when I first started coming to the home they showed me around and have always been very accommodating."

People and records confirmed the staff monitored people's health and care needs, and acted on issues identified. For example, Comments included, "If I have an accident they have to send over to the surgery to get a nurse."; "They keep an eye on me and get the doctor out if I need him."

People were supported to eat and drink enough and maintain a balanced diet. People had jugs of water in their rooms and staff were seen replacing these jugs with fresh jugs of water. The registered manager was in the process of revamping the four week menu. She said she was trying to ensure it was more balanced for people. People were complimentary about the food at the service. Comments included, "We can say in advance if we want something different. Quantity rather extreme at times. He is a very good cook doesn't waste food."; "The food is very good here." One person made us aware they could have a cooked breakfast on a Wednesday and Saturday, which they said they enjoyed.

We observed a lunch time meal with 14 people using the dining room with others choosing to eat in their rooms. People were advised about the menu option which was recorded on a large whiteboard. Staff had asked people their meal preferences during the morning. They had a choice from a four week rotating menu. On the day of our visit it was cottage pie or Cornish pasty although there was only one option of dessert,

banana cheesecake. Staff were attentive to people's needs and responded quickly to requests. People had various drink options which included lemon, blackcurrant and orange squashes. People's meals were served up in the kitchen and brought into the dining room by care staff and given to people a table at a time.

The cook was knowledgeable about different people's dietary needs and who required a special diet. The regularly update list which was used each day to ask people's views, identified people's dietary needs whether they were diabetic or required a soft consistency. Staff had gathered information about people's dietary requirements, meal sizes, likes and dislikes when they first arrived at the home. However there was very little choice for people requiring a specialist diet, for example people with type one diabetes. The registered manager was aware of this and was adding a selection of diabetic choices onto the new menu.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented in stainless steel serving dishes. The cook said it helped to make it look for appetising and people could distinguish the different food types and colours. People at risk of weight loss had their weight monitored regularly. During our visit we identified most people had maintained their weight.

Good

Is the service caring?

Our findings

Staff were kind and friendly towards people and were seen positively interacting with them, chatting, laughing and joking. People's comments included, "The staff are caring, if I ask for anything they would answer my request quite quickly they are all good."

A staff member said, "I think all of the staff are good, I can't fault that, they are 100% cared for, sometimes I think we care too much."; "We care about the residents."; "It would be ideal for my gran she would get all of the care she needed here." "The staff are absolutely superb, the odd one lets the team down but 95% of staff are here because they care about the residents…they treat them with respect and like to maintain their dignity.": "All of the staff are really friendly and they look after them (people) really well."

Staff were considerate and caring in their manner with people and knew people's needs well. Staff used friendly and supportive care practices when assisting people in their daily lives. We observed a care worker support a person who had received some flowers in the post. They took time to discuss the flowers, assisted the person to read the card, arranged the flowers and asked where they would like the flowers put so the person could enjoy them.

Staff treated people with dignity and respect when helping them with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, covered people and gained consent before providing care.

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in, where they spent their day and the clothes they wore. Staff said they knew people's preferred routines such as who liked to get up early, who enjoyed a chat and who required reassurance and emotional support.

People's relatives and friends were able to visit when they liked. People and a relative said they were made to feel welcome when they visited the home. One person said, "I can't grumble I get plenty of visits from my family who are always made to feel welcome."

People's rooms were personalised with photographs, personal eiderdowns, teddy bears on beds and ornaments. On people's doors there were their names and photographs to help familiarise them.

In the main entrance a table with Easter decorations, bonnets and eggs were on display. There was also a notice inviting visitors to help themselves to refreshments. There were two other notice boards with leaflets and information for people and visitors to the home. The CQC rating for the home was displayed along with the complaints procedure.

Requires Improvement

Is the service responsive?

Our findings

People received care that was personalised. However care plans identified people's medical history and health needs but did not guide staff how to support people safely. For example guiding staff regarding someone with diabetes what they should look for, foot care, skin integrity, meal choices. Another person had mental health needs and had medicines to help alleviate the symptoms they were experiencing. However there was no guidance to staff about supporting this persons mental health needs. Where health professionals had requested people had daily exercises, these had not been added to the care plans. This meant people might not have appropriate consistent support to help their health needs. The registered manager said they would add more details to guide staff about people's health needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

Following the inspection we were made aware that the local multidisciplinary team had expressed concern about the care plans and communication not being effective at the home. Their representative had met with the responsible individual to look at ways to improve the communication at the service to ensure staff had the information they needed to deliver people the required support.

The registered manager recorded in their PIR regarding how they were responsive to people's needs: 'Person centred care plans completed within a week, diversity and culture of resident is taken into account…care plans are person centred not task orientated.' We observed that people's care plans had been completed within the week of their admission to the home and took into account and were person centred.

Although more guidance for staff was needed in care plans there had been some improvements in the documentation and care records. The registered manager had put in place a comprehensive pre admission assessments for all new people coming into the home. They had gone and met with new people to ascertain their needs, views and wishes and to assess whether the service could meet their needs.

The registered manager had prioritised people's care plans and documentation. They had been working with the local authority quality assurance team and had re written everyone's care plans and rearranged the care folders. The newly formatted care folders were presented in an orderly and easy to follow format. The registered manager had spent time ensuring people's plans were person centred and gave a very good picture of the people and their history. They had supported people to complete the Alzheimer's society 'This is me', a booklet to help support people in an unfamiliar place. It asked people questions about what routines were important to them, things that may worry or upset them and what made them feel better if anxious or upset.

Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in people. One staff member commented, "I prefer the new care plans, the way they tell you a lot more, you read it and get a real feel for the person." Staff were advised about people, what they wanted to

be called, important people in their lives, backgrounds, skills and interests, likes and dislikes. People's care folder included personal information and identified the relevant people involved in their care, such as their GP, optician, hairdresser, community psychiatric nurse and chiropodist. There was a wide range of care plans which covered people's safety, cognitive ability, biography, personality, eating and drinking, sensory impairment, spirituality, occupation, entertainment, family, friends and community. This meant that when staff were assisting people they knew their choices, likes and dislikes and provided appropriate care and support. In one person's care plan staff had recorded, "Tips for talking to me, I enjoy talking to people and have no communication difficulties."

Care plans were person centred about people and their pasts, social need and wishes. They addressed people's anxieties and mental health needs. For example, one recorded, "I don't like change and can become quite upset and angry if things around me change, this can be new residents or carers". There were clear instructions to staff how to address these anxieties. For example, "If I become withdrawn or aggressive throughout the day you can help me by siting with me and listening to what I have to say. Listening to what I have to say and explaining to me why changes have happened and how they will affect me." Another care plan recorded, 'Areas of risk for me' and for one person was recorded, 'I have a tendency to wander around the grounds and have been seen leaving'. Staff were guided to 'to keep me safe remind me if I am wishing to leave the premises to inform a member of staff."

People were given the opportunity to be involved in reviewing their care plans. Staff had completed consent and treatment paperwork regarding personal care and support, care plans, photographs and to, share information. People had been asked the frequency they wanted to be involved in undertaking a review. On a staff notice board outside the kitchen a note from the registered manager reminded staff that people could read their own notes and also write in their own daily notes if they chose. The note also reminded them what they should include when writing in people's daily notes. For example the care provided activities, achievements and choice.

We observed at the lunchtime meal that protective aprons were placed on people with no discussion or any sign that people were being involved in the decision making. We discussed this with the registered manager who said they had recognised the dining experience for people could be improved and had plans to make improvements.

The provider employed an activity person for 16 hours a week. People spoke positively about the activity person and said they enjoyed the activities when they were on duty. One person's comments were, "Highlight of the week is the activity person (name) coming. She wakes everyone and gets them involved. She comes Monday, Tuesday and Thursday. I have a carer go with me if I need to go over to the shops." In the main entrance there was a plan to identify the activities on offer for the week with something recorded on the day the activity person had worked. There was a social activity log in the back of each person folders which the activity person had recorded the activities people had undertaken. The registered manager said she was working with staff to get them to record the activities care staff had delivered on this sheet. Although we did see some entries in people daily notes of activities staff had undertaken.

The registered manager said activities were provided at other times by staff on duty and by people booked to come into the home. We saw that an external entertainer had been scheduled to come to the home on 12 April 2016 and the local vicar delivered a service at the home every six weeks and a weekly hairdresser visited. Staff said they felt people would benefit from more interests but it was limited what they could do. On the first day of our visit people said there was nothing planned for the Easter weekend. On our second visit people said they had not had any special event over Easter except their usual tea in front of songs of praise. The registered manager said activities was an area she wanted to develop further but needed to get

the staff levels in place first.

The atmosphere at the home was welcoming with people living there appearing 'at home'. The main lounge was comfortable with an activities corner. There were magazines, newspapers and books that people could help themselves to and board games. There was a house cat at the home seen sitting on people's laps with food and water for the cat available in the fire place. People had numerous interactions with the cat and everyone was very positive about having it at the home.

We observed one visitor playing scrabble with a person who said they enjoyed the game. During our visits two people went out for a walk and one person regularly sat outside to enjoy a cigarette. They said they felt quite happy at the home and were well looked after." The television was on for most of our visit with the BCC news channel showing. One person said, "It stays on the news unless there is a special film or on Sunday we have our tea in the lounge so we can watch songs of praise." We discussed this with the registered manager who said it was not always the case. They confirmed they would ensure people made choices about the programs they watched.

People were supported to access their local community and keep in contact with friends and family. One person who had come to the home liked to play bowls. The registered manager had taken them to the local bowling club and had introduced them and the person had signed up as a member. This person said they were really pleased to be able to join and although they could no longer play were looking forward to watching the games when the season started.

Staff supported people to maintain their independence. One person said how they liked to lay the tables making sure there was salt and pepper, and drinks for people. This had been recorded in the persons care plan, which said, 'Support me to be able to feel needed by asking me to help set the tables or clear them. How to support me to maintain my cultural identity, support me to keep busy by helping in the dining room." We observed that the person was actively encouraged at the mealtime. The person had also taken on the role to deliver people's mail, which they appeared to take great pride in.

The provider had a complaints procedure which made people aware of how they could make a complaint. It also identified outside agencies people could contact which included, the local authority and government ombudsman.

People and relatives said they would feel happy to raise a concern and knew how to. Comments included, "I have no complaints, but would like more activities.": "I would tell the boss… would sort it out."; "The manager I suppose, if it is to do with nursing I would consult the senior or one of the carers and they would report the matter."

There had been no formal complaints received at the service since the new registered manager had started at the service. Where the registered manager had been made aware of grumbles they had taken them seriously and had taken action to ensure people were happy and satisfied with the outcome. They said, "I work on not having any, if someone says something, I act upon it as quickly as I can. We have the occasional grumble. " They gave an example of a relative concerned about a person not having a shower the day they were due to have their hair done. The registered manager had taken action and after discussing it with the person arranged for them to have a shower straight away. A complaint which had been dealt with at the service prior to the registered manager starting which had been investigated and responded to in line with the providers complaints policy. As an outcome of the complaint additional staff training had been implemented.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was a registered manager in post. However, they have now left the service and the provider is actively recruiting another registered manager.

A range of quality monitoring systems in use which were used to continually review and improve the service. Each week the registered manager completed a 'weekly report' which was sent to the responsible individual and the provider to keep them informed. The information included staff recruitment, occupancy and maintenance concerns. The registered manager had identified on the weekly report that the drive leading to the home needed to be addressed as it was uneven with pot holes, this was still under discussion. The registered manager said they were confident the provider would act upon concerns highlighted. Their comments included, "If I give a reason I need something regarding safety they are generally pretty good."

The registered manager had implemented a program of audits in January 2016. The programme included monthly audits of the medicines, care plans, accidents and incidents, health and safety, cleaning, compliments and complaints, mattress maintenance, infection control, new staff and staff leaving and people's weights. The registered manager had identified the system to ensure people had their prescribed topical creams was not effective and had been taking action to address. The medicine audits had not identified some medicines had not been entered into the register as required, handwritten entries onto people's medicine records had not been signed. It had not been identified that the environment was not always safe for people who used the service, visitors and staff. Fire and risk assessments were undertaken but had not identified the concerns we found.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

We saw that following an audit of a sample of people's care plans an action plan was developed. The plan was given to senior staff. However there was no system to check these actions had been carried out. The registered manager said she would address this concern

Staff spoke positively about how the registered manager had made significant changes and improvements at the home. They said they had worked with them and encouraged an open culture. Staff comments included, I think (registered manager) is a brilliant boss very approachable and will challenge staff if she needs to."; "(Registered manager) will sort this out, we are getting there, they don't all listen though.": "I think it is good…it is getting there, go to (registered manager) and tell her, she listens. We asked could we have some more flannels and there were more."; "She is on the ball, things are tried, she listens to everyone's opinion."; "Runs it ok it is improving, there has been a lot of tittle tattle but it is getting better."; "The manager is good but needs support, the carers don't have the knowledge."

People were also positive about the impact the registered manager had made at the service. One person said, "Managers' seem to come and go, there have been several since I have been here, we just get used to them and then they leave. (Registered manger) is very energetic and doing vast alterations indoors and

out."; "Not seen too many changes, quite happy with how things are and the new manager."; "The atmosphere here has changed for the better. " In response to a survey sent to relatives in September 2015 one relative had recorded, 'improvements are noticeable since the new manager started and goals are being set and worked towards.'

The registered manager was supported by the responsible individual who visited the home on a weekly basis. The registered manager was positive about their support and input. They said, "(Responsible person) is an amazing support he was here two to three times a week at first now not so often and is always available on the phone." They went on to tell us that following their visits they had recently started receiving an email setting out what had been discussed and what needed to be done.

The responsible individual and registered manager had been working with the local authority quality assurance and improvement team. The quality team had completed a report following their visits setting out their findings, progress made and recommendations. The reports are sent to the responsible individual and the registered manager to keep them informed. Following the quality team's advice the registered manager had been completing a 'service improvement plan'. This set out the issues they had identified, the action plan and timescales to address and by whom. For example, they had recorded, 'care plans and daily records are task focused', with actions which included completing care plan and daily records training, to be completed by January 2016. This had not been completed. It was evident that the registered manager had made significant progress in completing actions identified. However they had not regularly reviewed the planned completion dates which most had passed and had not added new identified risks to the improvement plan. The registered manager said they would review the improvement plan and update the timescales.

The registered manager was in day to day control at the service. They undertook unexpected visits to the home at different times of day to monitor the continued safe running of the service. The registered manager said "I am at the home most weekends to keep an oversight as the (administrator) was at the home weekdays. I have a huge passion for the home and bring my dogs in, I pop in all of the times. I am fair I don't ask others to do things I am not prepared to do."

People's views and suggestions were taken into account to improve the service. The registered manager recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided. For example, resident meetings took place to address any arising issues and the registered manager ensured they spent time with people on a regular basis. The last relatives and residents meeting held in November 2015 had been well attended with 11 relatives and 10 people present. The records of the meeting demonstrated that people and their relatives were actively involved in discussions about the service. Topics discussed included, staff recruitment and staff leaving, new menus being developed. Another meeting had been scheduled for the 12 April 2016. In addition, surveys had been completed by people using the service. The surveys asked specific questions about the standard of the service and the support people received. Comments seen were on the whole positive. However the responses had only been seen by the registered manager and responsible person. They had not been collated and actions made and shared with people and their families to inform them.

Staff were consulted and involved in decisions making about the service through regular staff meeting and said they felt listened to. We observed staff interacting in the staff meeting which took place during our visit which was well attended. The registered manager asked staff their views about the management structure and made them aware of proposed changes. Staff were thanked for their hard work and staff were able to raise issues which were discussed openly. For example, the need for the kitchen assistant to start earlier and the plans to have a head house keeper. Since starting at the service the registered manager had held specific

meetings with the kitchen staff, care staff, and senior staff and three whole staff meetings. They said they planned to undertake a full staff meeting every four months unless a need arose to have an additional meeting.

The service worked with other health and social care professionals in line with people's specific needs. People and staff commented that communication between them and the other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP's, speech and language therapist and community psychiatric nurse. Regular medical reviews took place to ensure people's current and changing needs were being met. Health and social care professionals confirmed that the service worked well with them and took on board things requested.

Staff had access to a range of policies and procedures to guide their practice, which were in the process of being reviewed and updated. We discussed with the registered manager that the medicine policy still reflected that registered nurse undertook medicine administration at the home. They said they would prioritise their medicine policy to reflect the changes at the service.

In March 2016 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored four with the highest rating being five. This confirmed good standards and record keeping in relation to food hygiene had been maintained. Where they had recommended actions these had been acted upon. For example, a shelf had wooden braces, these had been painted, and a freezer which had deteriorated seals had been taken out of action.

There were accident and incident reporting systems in place at the service. The registered manager reviewed all of the incident forms regarding people falling. They looked to see if there were any patterns in regards to location or themes. Where they identified any concerns or reoccurrence they took action to find ways so further falls could be avoided.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as when a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested and working in line with their registration.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not detail people's health needs to ensure their health needs were met. This is a breach of regulation 9 (1) (b) (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of peoples medicines. This is a breach of regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers system to asses the risks of health and safety concerns to ensure the welfare of people using the service were not effective. Regulation 17 (1) (2) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people's safety by doing all that was reasonably practical to mitigate risks. They had not identified fire risks at the service to ensure the premises were safe. This is a breach of regulation 12 (2)(b)(d)

The enforcement action we took:

Warning notice