Avon Care Limited

Grosvenor Hall

Inspection report

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Scarborough
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Date of inspection visit:
15 June 2016
16 June 2016

Date of publication:
01 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Grosvenor Hall is a detached property on the south side of Scarborough. It provides a care home service for people living with dementia. There was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

When we walked around the premises we saw that some bedroom doors were propped open and safety gates were in place on some rooms. The fire prevention team completed a report and made recommendations to the provider to ensure the safety of people living at the home.

The home's infection control procedures were poor and following a visit by the infection control nurse several areas that required improvement were identified. Clinical waste was not being disposed of as per the service policy. You can see what action we have asked the provider to take at the back of the full version of this report.

Staff we spoke with understood how to make an alert if they suspected anyone at the home was at risk of abuse. Training had been given to staff about safeguarding procedures.

Staff training was being completed via on-line and workbook methods. Training the service considered to be mandatory was being requested by the registered manager, to ensure training was current, to allow staff to support and care for people effectively.

The doors to the premises were kept locked at all times and people were restricted from leaving the property independently Appropriate safeguards were not in place relating to the Deprivation of Liberty Safeguards (DoLS) authorisations, that legally restrict the liberty of people, by preventing them from leaving the home independently. This meant that people were being restrained without the legal authorisation in place to do so. Applications had not been made in line with the required lawful practice. You can see what action we have asked the provider to take at the back of the full version of this report.

People were supported to access external professionals to maintain and promote their health. Care records detailed appointments people had with healthcare and social care professionals.

Relatives and people made positive comments about the caring and compassionate approach the staff demonstrated. Staff were kind to them and respected the dignity and privacy needs of people. Relatives were made to feel welcome when they visited the home and there were no restrictions on when they could visit people.

Staff had a good understanding of people's individual care needs and we observed them supporting people

to make choices. However people were not always involved in reviewing their plans when needs changed.

People were not supported to access activities that met their needs and preferences. There was a lack of support to follow their interests or appropriate access to social stimulation, either in the home or out in the community. You can see what action we have asked the provider to take at the back of the full version of this report.

The service did not have robust systems in place to monitor the quality of the service. Audits had not been carried out to minimise risks to people and ensure good practice was maintained. Relatives had completed surveys, but their views and opinions had not been acted upon to ensure the service ran smoothly and acknowledged areas for improvement. You can see what action we have asked the provider to take at the back of the full version of this 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

The service was not consistently safe.

The service did not apply good infection control practices to keep the home clean. People were not protected from the risk of infection and the service did not follow their clinical waste policy.

Regular water testing for legionella bacteria had not been carried out at the service, putting the health of people at risk.

Fire safety was of concern and the fire prevention team were asked to visit by CQC. They made recommendations to the provider for improvements to be made to ensure the safety of people in the event of a fire.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Deprivation of Liberty Safeguards (DoLS) applications had not been made for people in line with legislation. This meant that people were being prevented from leaving the home independently without the required legal authorisation in place.

People's nutritional needs were met. The menus offered variety and choice and provided a nutritious, well-balanced diet for people living in the home.

People were supported to maintain good health and access health and social care professionals as they required them.

Is the service caring?

Good

The service was caring.

People spoke positively about the care they received and said they were treated with kindness and compassion.

Feedback from relatives was positive regarding people being treated with dignity and respect. Relatives could visit people

when they wanted to.

Staff understood how to support people to make choices that encouraged them to remain as independent as they wanted to be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff had a good understanding of people's individual care needs and respected their choices.

People told us that they did not have input into their care planning and reviews.

People were not offered activities or stimulation to follow their interests, inside the home or in the community that met their needs or supported person-centred care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to audit and monitor the quality of care and support provided were not sufficiently robust.

Relatives had completed surveys, but their views and opinions had not been acted upon.

People and staff told us the manager was approachable and always visible in the home.

Grosvenor Hall

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 16 June 2016. The inspection was unannounced and undertaken by one inspector. Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We received a Provider Information Return (PIR) from the service. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information on the completed PIR to support our judgements and also gathered information we required during the inspection visit.

During the inspection visit we spoke with five people who lived at the home, four visitors, five members of staff and the registered manager. After the inspection visit we spoke with four health and social care professionals. We contacted a fire prevention officer and an infection control nurse in relation to our observations during our inspection visit. We also contacted the local care services team and their views are included in this report.

We looked at all areas of the home, including people's bedrooms, when they were able to give their permission. We spent some time observing care in the lounge and dining room areas to help us understand the experience of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the lunchtime experience and interactions between staff and people living at the home.

We reviewed five people's care plans and associated documentation. We observed medication being administered and checked the medication administration records (MAR). We also looked at the recruitment, training and supervision records of four members of staff.

We reviewed documentation, which included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas.

Requires Improvement

Is the service safe?

Our findings

People and relatives we spoke with told us that they felt safe at Grosvenor Hall. One person told us, "I know I'm safe here." Another person said, "Everything is alright with my safety and the staff are gentle with me." A relative we spoke to said, "I know [relative's name] is safe here, the care is really wonderful." Another relative told us, "I think they are very safety conscious here and there are enough staff." They went on to say "They [staff] move [relative's name] safely, so they've had the training."

However, when we observed and reviewed the health and safety of the environment and the premises, we found some areas of the home which were potentially unsafe and presented a risk to people. The main hallway had a mattress leaning against the wall. In another hallway we saw a step ladder and a large picture were left unattended. These potential trip hazards meant the environment was not safe as people were at risk of harm.

Throughout the home surfaces and flooring were in a poor state of cleanliness. For example, bedroom carpets were stained and worn and the laundry room sink was stained.

We observed used incontinence pads that had been disposed of in tied bags within a general waste bin. Although we understood that the local authority allow a certain amount of clinical waste, that has been double bagged, to be disposed of in general waste bins, the service policy on clinical waste stated that yellow clinical waste bags should be used for disposal of incontinence pads. This increased the risk of infection.

A healthcare professional we spoke with had observed that staff did not always wear gloves and aprons when giving personal care to people, including when staff were moving people and administering care regarding pressure areas. These items were available, but not being used in-line with the service infection and control policy.

Following the visit to the service we discussed these areas of concern with an infection control nurse, who completed a visit to the service and provided us with a copy of their findings. Their report raised areas of concern including the general environment, lounges, dining room, bathrooms, bedrooms and the laundry room. Recommendations were made to the provider about steps which needed to be taken to reduce the risk of infection to people living at the home.

There were two stair lifts in the building and they were both purchased in January 2016 in working order and within warranty. The gas safety certificate was in place and in date and testing of small electrical appliances had been completed and recorded appropriately. However, tests of the water had not been carried out since 2008, so people were not protected from the risk of exposure to legionella bacteria. Water containing legionella bacteria can cause infection and illness for people. Therefore the lack of testing put the health of people at risk, and meant that the provider did not meet their health and safety obligations.

There were exit signs displayed around the building and records confirmed to us that the fire extinguishers

had all been inspected regularly and within appropriate timescales. The fire system had received a full check on 20 May 2016, by the service that installed it. The staff had completed some recent training with a fire officer and had been advised of the evacuation process. Details of individual emergency evacuation plans for people were in their care plans and also on the back of each resident's bedroom door, giving guidance to staff of people's requirements in the event of an evacuation.

However, a fire safety audit was carried out on 10 May 2016 by the fire prevention and protection team and recommendations for improvement had been made. The registered manager told us that they planned to address the issues raised and to start weekly fire drill tests. However, these tests had not started at the time of our inspection despite this advice being given in May 2016. This indicated that the service had not taken timely action to improve the safety of the service for people.

We observed that "safety gates" had been put across two bedroom doors and that five people's bedroom doors were propped open and did not have any means of closing automatically if the fire alarm sounded. We considered this to be a risk to people's safety in the event of a fire and contacted the fire prevention team and asked them to visit and assess this area of risk.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

We reviewed the staff rotas and spoke to the registered manager about staffing levels. They told us they considered the needs of the people in the home and currently had four carers and one senior carer on duty in the morning time and into the early afternoon. From, 2.15pm onwards, three carers and one senior carer were on duty. There were two care workers on night time duty.

Care staffing levels were consistent, and one professional we spoke with told us, "There always seem to be enough staff there when I have been in." However staff told us that at times they felt very busy and that this was because they were required to fulfil ancillary duties in addition to their caring role. For example, the service did not employ cleaning staff, so the care workers were completing domestic duties when times were quieter throughout the day and night-time shifts. One staff member we spoke with told us, "I do cleaning in the afternoon and will clean rooms, change bedding and hoovering. I will do laundry too and night staff do the laundry as well and will take clothes to people's rooms."

It was evident that this arrangement was not working effectively as cleaning was not being carried out to a satisfactory standard using this approach and staff felt under pressure in delivering their caring responsibilities.

Also, the cook had been off work for several weeks at the time of our inspection, so the registered manager and a care worker had been doing the cooking.

We recommend that the provider review the ancillary staffing arrangements to ensure that cleaning and other domestic services are delivered effectively without impact on staff's caring duties.

The staff files we reviewed indicated that staff had been recruited safely with checks carried out by the Disclosure and Barring service (DBS) and they had wo references in place. The DBS checks assist employers in making safer recruitment decisions by checking prospective care worker members are not barred from working with certain groups of people. This meant that the home had taken steps to reduce the risk of employing unsuitable staff.

We saw there were safeguarding policies and procedures in place. Staff had received safety related training, including safeguarding and alerter training, first aid and health and safety.

Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. One staff member told us, "If I saw anything I was concerned about I would report it to my manager or a senior worker."

Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. One staff member said, "If I saw something that shouldn't be happening then I would report it." The staff handbook gave clear guidance to staff regarding safeguarding and the whistle-blowing process and instructions to seek advice from their manager if they were unsure.

When we reviewed people's care plans we saw that risk assessments were in place and were linked to the persons identified needs. One section of the care plan detailed risk assessments which were reviewed regularly with any changes recorded. These related to nutrition, falls, moving and handling and the environment. One professional we spoke with told us, "One person, on bed rest for a long time has been well looked after. [Person's name] is pain free, with good skin integrity, so they are reducing the risk with good care." Speech and Language Therapy (SALT) team referrals were made when required and we saw that related guidance for staff was in care plans. This indicated that risks to people's health were identified and appropriately managed and reviewed by the service.

Accidents and incident were recorded in people's individual care plans. The registered manager told us that when care plans were reviewed, patterns were identified and referrals to appropriate professionals were completed. For example, one care plan we viewed contained body diagrams, along with an appropriate risk assessment tool that had been used to identify the risk associated with pressure areas.

We observed medicines being administered safely to people and the staff member was courteous and patient. They ensured people had taken their medication before signing the Medicine Administration Records (MAR). The medicine storage room was tidy and the temperature of the room and the storage fridge were within the required ranges and recorded daily. The Medicine Administration Records (MARs) were up to date and reflected the medicines given. The controlled drugs (CD) cupboard and stock book were appropriately managed and secured. CD's are medicines that have strict legal controls to govern how they are prescribed, stored and administered. The medication returns book recorded medication returned appropriately. Medication that had an expiry date on it was clearly marked to ensure it was disposed of before it expired. Any un-used medication was collected for disposal regularly and recorded.

One person told us, "They bring me my medication on time." A relative we spoke with said, "I have seen medication being given to people safely." Care plans we reviewed contained medication reviews that were completed monthly and updated when changes in medication took place. The staff handbook gave guidance to staff regarding medication and stated that they would be required to complete training before administering any medication. This meant that people received their prescribed medicines safely from appropriately trained staff.

Requires Improvement

Is the service effective?

Our findings

People we spoke with made positive comments about the skills and knowledge of the staff who supported them. One person said, "Staff are very adaptable, they are trained to do anything and everything." Another person told us, "They [staff] look after me well." A relative we spoke with told us, "The staff all appear to be good at their jobs and look after [relatives' name] really well."

Despite this positive feedback from people, we had some concerns in relation to how the service managed Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005. One staff member told us, "If I felt someone's mental health was deteriorating I would talk to my manager about it, so that they could look into things further or refer the person to the right service for professional support." When we spoke with the registered manage they told us, "We do not make any assumptions that people lack capacity, but if someone does appear to be losing capacity then we contact their doctor and they will complete an assessment, or they could make a referral for a full assessment and a formal diagnosis." However the registered manager went on to say that every person living at the home would be unsafe if they went out into the community on their own and that they were in the process of making applications for DoLS for every person who lived at the service, because the doors to the premises were kept secured at all times and people were restricted from leaving the property independently.

When we reviewed the care plans we found that one person had a DoLS authorisation in place, along with a record of 'assessment of capacity' that evidenced that they had completed a full assessment. The remaining residents did not have current DoLS applications or approvals in place that legally restricted their liberty. We contacted the local care services team about DoLS applications and they told us that the service had not submitted any DoLS applications recently. This meant that people were being deprived of their liberty without authorisation. Although the registered manager understood that the DoLS applications needed to be made for each resident they had not made the applications in line with legal requirements.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response from people. Staff told us they always ask for consent from people before giving care. One person told us, "The staff are lovely and I can talk to all of them. They [staff] always ask me if I want them to help me with my personal care."

We spoke to the registered manager about how they ensure that decisions for people are made in their best interest when required and they told us they involved families and relevant professionals, for example a doctor or social worker, and sought their opinions to ensure that decisions are made appropriately. A relative we spoke with told us, "I am asked about what I think is best for [relatives' name] and if a decision is alright with me. I am kept updated with any changes to the care being given." One staff member we spoke with told us, "Decisions being made for people must be the best ones for them and some people do have capacity to make some decisions, but not others." This meant that best interest decisions were being discussed with family members and professionals and staff acted appropriately in relation to making decisions for people in their best interest and gaining their consent.

When we spoke to staff about their induction into the service they told us they completed a period of induction and shadowed more experienced workers before they started to deliver care and support to people independently. We reviewed staff files and found they contained an induction checklist and a form that the staff member signed to confirm they had read and understood the staff handbook and the service policies and procedures. Staff files also contained the employee's application form and proof of their identity. One staff member we spoke with told us, "We all work really well together as a team and I shadowed a senior care worker for a week when I started work here." This meant that staff had been inducted appropriately to fulfil their role.

We reviewed the staff training schedule and staff had received recent training including principles of dementia care, emergency first aid at work and understanding dignity. The registered manager told us that some of the training they considered to be mandatory was in the process of being renewed, to ensure all staff received consistent and on-going training to effectively meet the needs of people. Staff were accessing courses from an external training provider that included safeguarding, infection control and safe handling of medication. These courses could be accessed on-line or via a workbook, so staff chose the method of learning they preferred. Staff we spoke with confirmed that were completing training both on-line and through using workbooks.

Staff were able to progress professionally. One staff member had achieved their National Vocational Qualification (NVQ) Level 2 in Health and Social Care and had started their Level 3 NVQ. National Vocational Qualifications (NVQs) are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability and competence to carry out their job to the required standard.

Staff supervision meetings had recently been inconsistent. Supervision is an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support and for their manager to give feedback on their practice. However, although the regularity of supervision had decreased recently, the registered manager told us that staff did discuss any issues with them as they arose. Staff confirmed that they were confident to talk to the registered manager and made positive comments including, "The manager is very approachable and I could go to her with any problem." And, "I can talk to the manager, she is a good boss." The supervision records we saw were detailed and recorded that discussion had taken place around areas including, workload, concerns, team issues, actions to take and achievements.

Appraisal meetings for staff took place on a six monthly or a yearly basis and were recorded and reviewed appropriately. They included a review of the previous appraisal period and logged discussions with staff about topics including, their training needs, role development, any difficulties and any areas for improvement. This meant that staff were supported by the registered manager to raise concerns, review their practice and development needs to allow them to deliver effective care and support to people.

We observed that staff had the ability to communicate with people effectively and they were patient and calm, offering reassurance to people when required, interacting with them in a positive manner. One staff member told us, "We are patient with people and don't rush them, we need to go at their pace and we always get there, so we know what someone is trying to tell us." A relative we spoke with said, "They [staff] communicate with [relative's name] kindly and in a patient way. They [staff] understand her needs and [relative's name] responds to the staff well." Care plans we reviewed contained guidance for staff, for example, to give lots of reassurance when talking to and explaining things to the person.

The service had been awarded a food hygiene rating of five, which was displayed in the home. A whiteboard in the dining room detailed the meal choices available and we observed that meals were planned on a four weekly rotating menu. A file kept in the kitchen contained recipes specifically for people with diabetes and one person we spoke with told us, "I am a vegetarian and they [staff] look after my meals." A relative told us, "[relatives' name] was anxious at home and didn't eat, but has made good progress here, is eating well and has put weight on."

We observed the lunch mealtime experience for people and the food looked appetising and people were offered a choice of drinks. Staff were attentive to people's needs, and offered support if required. People were not rushed to eat their meals and we observed them chatting to each other in a calm and pleasant environment. People confirmed to us that they enjoyed the food and could have snacks and drinks throughout the day. People had their meals in their room if they wanted to. One person told us, "They [staff] bring my supper to my room." Another person told us, "The food is very good. Full meals with fresh vegetables and I enjoy my food." This meant that people were given a varied choice of good quality meals to maintain a healthy diet and had the support they required at meal times.

The health needs of people were met and staff referred people to healthcare professionals as required. Information was recorded in people's care plans about their health needs and risk assessments were in place. However, we saw that people had not been weighed since January 2015 due to broken scales and no screening tool used to determine peoples risk of malnutrition. MUST is a screening tool used to identify adults, who are malnourished or at risk of malnutrition. Despite this, we had seen people eating well and did not see anyone who looked underweight.

Healthcare professionals we spoke with made positive comments including, "If the staff have any concerns they will ring for guidance and support." And, "We have good communication and they follow the advice given to them." One person told us, "If I need a doctor, they call one for me straight away." A relative we spoke with said, "I am told straight away if [relatives' name] needs to see a doctor and they keep me informed." One person had been referred to the speech and language therapy team (SALT) and the persons' care plan confirmed that the appropriate support and guidance was in place and was reviewed and recorded regularly. Their relative told us, "They have ensured the right type of bed and mattress is in place and [Relatives' name] had lost interest in eating, and the staff are following the SALT advice and doing everything they should."

The premises had been adapted, with the installation of stair lifts for people who could not easily use the stairs. There were hand-rails in place throughout the building for people to use when moving around the

premises. This meant that the mobility needs of people had been recognised and appropriate adaptations had been made to meet those needs.

Good

Is the service caring?

Our findings

People spoke highly of staff. One person said, "I am happy here, the staff are caring and kind towards me." Another person told us, "I have no worries at all, it is a home from home for me." They went on to say, "If I were feeling a little bit upset I could ask for a cuddle if I need one and I can talk to the staff about anything." When we spoke with relatives about the staff approach they made positive comments including, "The staff here are wonderful, they are all so nice and have been like family to me." And, "Staff are fabulous when caring for [relative's name]. I have seen it for myself and I am here a lot." Another relative said, "The most important thing for me is the relationship [relatives' name] has with the staff and she smiles when she sees them, so I know she is happy."

We observed staff speaking to people respectfully, they took the time to listen to them and knew them by their first names. People told us that if they wanted to have some privacy, that their wishes were respected and they were treated with dignity. One person we spoke with told us, "I like to spend time in my room and staff respect my privacy. I also have nice chats with the staff and I like being here." A relative we spoke with told us, "The dignity and privacy of [relatives' name] is respected at all times and staff know [relatives' name] well." Healthcare professionals we spoke with made positive comments, including, "When I have visited I have seen good, caring and kind interaction between people and the staff." And, "I have seen staff include people in conversations and show a friendly and caring approach to residents."

We spent time with people in the communal areas and observed that there was a relaxed atmosphere. People were comfortable and happy around staff and they chatted and laughed together. Staff were patient with people and listened to them, offering explanations before care was provided. For example, one person was given a clear explanation and the time they needed to respond when their medicine was being administered. When we spoke with staff about their relationships with people they made comments including, "I have a bond with the people I support. We will chat about things and spend time getting to know people. This builds our relationship and builds their confidence in us, which is good." And, "We always explain what we are going to do and ask if it is alright with the person." This meant that staff had a good understanding of the importance of offering people explanations and giving them time to respond when making decisions.

We observed several visitors being welcomed by staff and one relative told us, "Staff are really friendly and I can have a cup of tea and a meal if I want to." They went on to say, "I know [relatives name] is happy and that the staff care." Another relative said, "The girls always get me a cup of tea when I visit." There were no restrictions on when family and friends could visit people and we observed visitors arriving throughout the day.

People could decide when they got up or went to bed and could choose to have their meals in their room if they wanted to. One care plan we reviewed detailed how a person might come downstairs for a chat and a warm drink during the night. A staff member told us, "People like to stay up until different times and we will ask them if they want to go to bed, not force them." Another staff member said, "I treat people how I would want to be treated. We are here to make sure people are cared for and I do care about them."

Staff told us that a local vicar routinely visited to 'say hello' to people in general. At the time of our inspection there was no-one with any specific cultural or religious needs. However, one care plan we reviewed detailed that if the person wished to attend a church service, then they would be accompanied by a staff member. The service had an equality and diversity policy in place and it offered appropriate guidance for staff.

The importance of peoples' confidentiality was understood by staff and the service had a confidentiality policy in place, which was also detailed in the staff handbook. Staff were able to tell us that they are aware of the importance of information about people remaining confidential and one staff member told us, "We must always keep information we know confidential, as it is private. Peoples files are locked away to keep them safe." Another staff member told us, "We don't talk about people's private business in front of other people, or to anyone." We observed that people's files were stored securely in a locked cupboard.

We spoke to staff about how they supported people to maintain their independence and one staff member said, "We encourage people to be as independent as they want to be and then we are there to offer support to people when and how they want it." Another staff member told us, "Part of being independent is being able to make your own choices and this is their [people's] home and it is their choice what they do. For example, we will encourage people to come downstairs during the day, and we respect their choice if they want to or not." This meant that staff were sensitive to people's choices and acted upon them.

At the time of our inspection no-one was receiving end of life care at the service. We found that where people wished to make advance decisions regarding their choices, these were recorded appropriately in their care plans giving guidance to staff on their preferences and wishes. Staff had received training in end of life care.

Requires Improvement

Is the service responsive?

Our findings

People expressed varied opinions when we asked if the service was responsive to their needs. One person told us, "Staff look after all my needs and I am happy here." Another person told us, "I'm bored there's nothing to do here. You'd be bored just sitting here." A relative we spoke with told us, "I have seen [relatives' name] care plan and they [staff] have shown me what medication [relatives' name] is on and will talk to me about any changes in their care." They went on to say, "People here need more mental stimulation." Another relative told us, "I take [relatives' name] out to the local park in a wheelchair, but there are no activities to go out organised by the home." A staff member we spoke with said, "There is no real stimulation for people with dementia and no activities to go outside or into the community."

When we asked people about their input into their care planning and the on-going review of their care needs, they told us they did not have any input into their care planning. One person said, "I'm not sure what's in my care plan." We found that care plans were reviewed every two months or sooner if required. However, the care workers completed the reviews without involvement from the person being reviewed. One care worker we spoke with told us, "We complete the reviews and don't really speak to residents about them if reviews are around the more practical changes." This meant that changes were made based on the view of the staff about what was relevant, without consulting people about their wishes and preferences or the need for change to their arrangements.

There were no activities taking place in the home to meet people's preferences or to give them any stimulation. The registered manager told us that they had a visit once a month from someone who delivered a 'singing for the brain' activity to people, but we considered that, although this activity had value, it was not adequate to meet the needs of the people living in the home. When we spoke to people about the activities available to them they told us, "We don't do any activities, a trip out would be nice." One care plan we reviewed stated that the person enjoyed arts and crafts activities, but they did not have support to access to any relevant activities to meet their needs and preferences. One relative we spoke with said, "I would like to see someone coming in to help with dementia, to do activities to keep them [people] going." A professional told us, "They could do more activities with people, to offer stimulation for those living with dementia. I have mentioned it to them before." This meant that people were not supported to follow their interests, engage in activities or maintain links with the community that would offer social interaction and stimulation to meet their needs.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

We saw that care plans contained a photograph of the person and contained information including areas regarding mobility, sleep, mental health, personal hygiene and dressing, dietary needs and communication. There was guidance for staff in each area, detailing the person's preferences, likes and dislikes. For example, 'likes a bath in the morning with assistance'. One care plan detailed how the person liked to have two pillows on their bed and their room at a certain temperature. Each care plan contained a section that recorded the persons identified and assessed needs, expected outcomes and goals, and the assistance to

be given to them. This provided staff with clear guidance to follow in each area, specific to the needs of that person.

The registered manager told us, "We go to families to gather information about people and care plans are available for them to see anytime they want to. The information helps to develop the care plan and lets us find out more person-centred details. It supports us to talk to people about their interests and their life." We found that where families had provided information about their relative it had been used to create a document called 'This is me', which contained information specific to people, including a photograph of them, their previous jobs, their life history, family history, how they communicate and their current and past interests. This document was available in peoples' bedrooms and staff told us they referred to this to get to know about a person. One staff member we spoke with said, "I look at the 'This is me' information and it adds to my knowledge about people and is really useful when we are getting to know them and talking to them about their life."

Staff we spoke with were able to tell us about people's care needs and the support they provided to people. They demonstrated an understanding of people's preferences and routines. One staff member said, "Some people need reassurance at times and might want to hold my hand and talk to me. I can tell if someone needs some reassurance and give them what they need."

We observed that staff respected the choices people made and encouraged them to come into the communal areas to gain some social interaction with other people. One relative we spoke with told us, "Staff always encourage [relatives' name] to come out of their bedroom and sometimes they will, sometimes they won't, but I am glad to see [relatives' name] is downstairs today."

A staff member we spoke with said, "This is their [peoples] home and it is their choice what they do. People make their own choices and that includes how they receive their personal care, the clothes they want to wear, their meals and we respect their choices."

People had their own personal belongings in their rooms and one person said, "This is my home now and I love my room. My sister comes and takes me out and I really like that." A relative we spoke with told us, "[relatives' name] has personal things in her room and the staff treat her as an individual. They are very good to her and I know she likes them." Another person said, "I have my own bits and pieces in my room and it's lovely. The staff are lovely and I can talk to them about anything." This demonstrated that staff understood how to support people to ensure they had as much choice as possible and responded to people's preferences.

When we asked people if they knew how to make a complaint or raise a concern, they told us that they would be happy to talk to a member of staff or the registered manager. One person said, "I would talk to the manager who is very nice." A staff member told us, "If someone wanted to make a complaint I would talk to my registered manager and I know they would do the best they could to help to sort out the complaint." A relative said, "I have not had to make a complaint, but if I did I would definitely talk to any of the staff or the manager." One relative we spoke with told us that they had raised the issue of a chest of drawers being broken and carpet that needed to be replaced. They said that the registered manager listened, responded within a reasonable time and did replace the items with new ones.

When we spoke with the registered manager about how they deal with complaints they told us that when they receive a complaint they look into it and write a response, for example, they would write to a family member who may have made a complaint and offer a solution and further discussion. The service did have a complaints policy in place and the registered manager showed us a letter of response they had sent to a

family who had made a complaint. When we looked at their record of complaints we found that complaints were logged and were responsive to concerns being raised.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place and people made positive comments about them that included, "The manager is very nice and is really helpful." And, "The manager is always around and pops in." A relative told us, "I know that if people want anything, they will get it. The manager is looking after things." And, "I can talk to the manager, they are very approachable." A staff member told us, "I think we have a great manager, who we can go to with a problem."

We observed the registered manager engage with people living in the home and people clearly knew them, responded positively and communicated openly. We observed the registered manager working with the staff team and it was evident that there were good working relationships in place. The registered manager explained that they had an 'open-door' attitude to staff and that they would ask them what they think and if they have any opinions and ideas. The registered manager told us, "I am 'hands on' and don't believe in being shut away in an office. I don't think you can provide a good service unless you are aware of what is happening day to day."

The statement of purpose of the home detailed a list of their aims, which included, 'To put the service users first', 'To meet the needs of the service users' and 'To meet the essential standards of quality and safety'. However, this was not always evident in practice.

We found that there had been two staff meetings during the past six months, in November 2015 and April 2016. We reviewed the minutes and topics discussed at the meeting in April 2016 and it included reminders for staff regarding attending training, checking the tidiness of residents bedrooms, spending time with people when they are in their bedrooms and in the communal lounges, holidays and sickness, amongst others. Although staff meetings addressed relevant areas to monitor the attitudes, values and behaviour of the staff, it was not clear if issues were being followed up or acted upon accordingly to provide staff with constructive feedback and a clear line of accountability. This demonstrated the potential for a negative impact on people and a lack of consistency in the how the service was managed and led.

When we spoke to the registered manager about surveys and questionnaires they had sent out to people, they explained that the last survey sent out to relatives was in November 2015. We reviewed the results and found there were 13 responses to this survey and the issue of the lack of activities had been raised by relatives. A previous survey has been sent out in January 2014. There had been ten responses to the survey and three of them had raised concerns around the lack of activities and stimulation for people. The issues raised had not been acted upon by the service which meant that they were not analysing the results of the surveys, via the views and opinions of relatives, to address the needs of people. They did not make changes to develop and continually improve the service.

The registered manager was approachable and present in the home and staff told us they felt supported. However, the registered manager acknowledged that the area of supervision needed to be reviewed to provide consistency in supporting staff to ensure the provision of an open and transparent culture within the service.

Notifications had been made to CQC appropriately regarding injuries, incidents and deaths. Notifications are when registered providers send us information about certain changes, events or incidents that occur. However, the provider had not made DoLS applications in accordance with legislation to support people who lived at the service and had not followed legal requirements.

We reviewed audits undertaken by the registered manager and found these to be out of date or not formally recorded. We also found that checks undertaken by the registered manager did not always identify or take action to rectify risks. For example, medication audits had last been completed in March and December 2015. The registered manager would choose three or four people's medicine records to audit. We also saw a medicines reconciliation audit document, which had been completed, but not signed or dated, so we were unable to establish when it had been completed. The registered manager told us that they planned to complete a medication audit every 3 months, starting in July 2016. However, we noted there had been nine months between the medication audits in 2015 and a further one had not been completed during the past 6 months. This lack of regular and complete medication audits meant that there was no means of identifying where improvements could be made to practice.

There were no other audits carried out by the registered manager. They told us they walked around the building once a week to see if anything needed fixing or replacing. This information was not recorded as an environmental audit, but any jobs identified were written in the 'handy-man book' so that they were made aware of them.

It was clear from the condition of the environment that infection control audits had not taken place and issues had not been identified. This meant that improvements to the environment were not being made and the health, safety and welfare of people who used the service was at risk. The service policy on infection control was not being followed by staff and the provider's quality assurance systems were not sufficiently robust to assess, monitor and improve the quality of the services provided. We concluded that people were not protected against the risks associated with the lack of good governance.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

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 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 The provider had failed to provide support for people to follow their interests, establish and maintain link within the community and take part in activities.

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 failed to ensure that the premises were safe for use by people living there. The provider had failed to protect people by doing all that is reasonably practicable to mitigate risk related to preventing, detecting and controlling the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had deprived people of their liberty without proper authorisation/lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service.

People were not protected against the risks associated with the lack of good governance.