Care Quality Commission

Embrace (England) Limited

Pavillion Care Centre

Inspection report

Pavillion Care Centre
North View Terrace
Colliery Row
Houghton le Spring
Tyne and Wear
DH4 5NW
Tel: 0191 385 3555
Website: www.europeancare.co.uk

Date of inspection visit: 27 May 2015, 2 June 2015 and 5 June 2015
Date of publication: 17/08/2015

Ratings

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

Overall summary

The inspection took place on 27 May 2015, 2 June 2015 and 5 June 2015. Our visits on 27 May 2015 and 2 June 2015 were unannounced. Our visit on 5 June 2015 was announced. We found the registered provider had breached the regulations because they did not have accurate records to support and evidence the safe administration of medicines. We also found that a daily check on the accuracy of MARs had also not been completed consistently. During this inspection we found the registered provider had not made sufficient progress since our last inspection and was continuing to breach the regulations.

Pavillion Care Centre provides nursing and residential care for up to 68 people. The home provides care and support for people, some of whom were living with dementia. At the time of this inspection there were 57 people living at Pavillion Care Centre.

Summary of findings

The home had a registered manager. 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.

We found the registered provider had continued to breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have accurate records and effective audits systems to support and evidence the safe administration of medicines. We found medicines had been signed for as administered when they hadn't been and some medicines were missing from people's blister packs. Checks had been ineffective in identifying and dealing with these issues. We also found the registered provider had breached Regulation 11 because the registered provider did not always act in accordance with the requirements of the Mental Capacity Act (2005) where people lacked capacity to consent to their care. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe living at the home. One person said, "It's just like being at home, but without the housework and cooking, I feel safe here." We received mixed views about staffing levels. People and family members said: "I think they need more staff, we don't get out on the bus as often as we should, it could be better"; "I think they all know what they are doing, but I think sometimes they are very short staffed"; and, "There seems to be a lot of agency staff." Most staff said there were enough staff, although they were very rushed, "People are not left. It is a struggle but we get round everybody. One extra staff member would make a big difference." The registered manager was making changes to how staff were deployed across the home. Most staff felt this would improve people's care.

People using the service gave positive feedback about the care delivered at the home. One person said, "They look after you well here." Another person said, "They don't mind how much they do for you here, I like coming here." We observed people received regular interaction from staff throughout the day.

We found the provider's approach to risk management was inconsistent. We found specific risk assessments had not been undertaken where people lacking capacity were at risk due to attempting to leave the home unsupervised. Staff had a good understanding of safeguarding and whistle blowing. They knew how to report concerns and all staff told us they would not hesitate to report concerns.

The provider had recruitment and selection procedures in place to check new staff were suitable to care for and support vulnerable adults.

The registered provider carried out a range of health and safety checks to ensure people's safety such as checks on the premises and equipment, checks on fire safety, window restrictors, specialist moving and handling equipment, electrical and gas safety. There were systems in place to respond to emergency situations. Each person using the service had a personal emergency evacuation plan which detailed their care and support needs in an emergency.

People were asked to give their consent before receiving any care and staff respected their decisions. Where people lacked capacity to make decisions a Deprivation of Liberty Safeguards (DoLS) application had been submitted to the local authority for approval.

Staff demonstrated a good understanding of the needs of people who displayed behaviours that challenged others. This included individual strategies to support people when they were anxious or distressed.

Staff were well supported and trained to carry out their caring role. One staff member said they were, "Fully supported. I can go to the nurse, clinical lead or manager. There is always somebody to turn to."

People did not always experience a pleasant dining experience. People were sat waiting for a long time before their meal arrived. We saw that menus did not accurately reflect the meal choices available. People received the support they needed to ensure they had enough to eat and drink from kind and considerate staff. Meals offered to people looked appetising except for pureed meals. We have made a recommendation about this.

People were supported to meet their health care needs. They had access to health professionals when required,

Summary of findings

such as community nurses, dietitians and physiotherapists. We received positive feedback about the progress the home had made from a visiting community nurse.

Staff had a good understanding of the importance of maintaining people's dignity and respect. People who wanted to were able to follow their religious beliefs.

Staff had access to detailed information about each person they cared for, such as their 'life history' and their care preferences. People had their needs assessed on admission into the home and this was used to develop care plans. Care plans we viewed were not always personalised and lacked sufficient detail to guide staff. Care plans had been reviewed regularly.

The registered manager was making changes to the activities programme so that people could access activities when they needed them most, such as at weekends and evenings. We observed the activities co-ordinator running a lively new initiative called 'Oomph.' We saw people were engaged with the activity and took part in singing and exercising. We have made a recommendation about this.

People and family members knew how to complain if they were unhappy. They told us they would be comfortable and confident going to the manager if they had a complaint. There were opportunities for people and family members to give their views about the care delivered at the home, such as regular meetings and questionnaires. The feedback from the most recent consultation was mostly positive.

We received positive feedback about the new registered manager from family members, staff and a visiting health professional. Staff told us the home had a good atmosphere. One staff member said, "Morale seems okay, I have not seen a sad face. The staff are friendly and approachable." One family member commented, "Staff are all very approachable, they contact me at home if they have any issues with [my relative]."

The registered provider had systems in place to assess the quality of the care people received. Action was taken to follow some audits to address areas for concern. A senior manager external to the service and an external quality team undertook regular monthly audits. The registered provider was working towards completion of an action plan developed in March 2015 following a CCG clinical quality assessment audit.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The registered provider had continued to not have accurate records and effective audits systems to support and evidence the safe administration of medicines.

People told us they felt safe living at the home. We received mixed views about staffing levels. The registered manager was making changes to how staff were deployed across the home.

We found the provider's approach to risk management was inconsistent. Staff had a good understanding of safeguarding and whistle blowing. They knew how to report any concerns. The registered provider had recruitment and selection procedures to check new staff were suitable to care for and support vulnerable adults.

The registered provider carried out a range of health and safety checks. There were systems in place to respond to emergency situations. Each person using the service had a personal emergency evacuation plan.

Is the service effective?

Requires improvement

The service was not always effective. The registered provider did not always act in accordance with the requirements of the Mental Capacity Act (2005). People were asked to give their consent before receiving any care and staff respected their decisions. Staff demonstrated a good understanding of the needs of people who displayed behaviours that challenged others.

Staff were well supported to carry out their caring role.

People did not always experience a pleasant dining experience. They received the support they needed to ensure they had enough to eat and drink from kind and considerate staff. Pureed meals offered to people looked unappetising.

People were supported to meet their health care needs. They had access to health professionals when required.

Is the service caring?

Good

The service was caring. People using the service gave positive feedback about the care delivered at the home. We observed people received regular interaction from staff throughout the day.

Staff had a good understanding of the importance of maintaining people's dignity and respect. People who wanted to were able to follow their religious beliefs.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive. Staff had access to detailed information about each person they cared for. People had their needs assessed on admission into the home. Care plans we viewed were not always personalised and lacked sufficient detail to guide staff.

The activities programme was being re-developed so that people could access activities when they needed them most, such as weekend and evenings.

People and family members knew how to complain if they were unhappy. There were opportunities for people and family members to give their views about the care delivered at the home, such as regular meetings and questionnaires.

Is the service well-led?

Requires improvement

The service was not always well led. We received positive feedback about the new registered manager from family members, staff and a visiting health professional. Staff told us the home had a good atmosphere.

The registered provider had systems in place to assess the quality of the care people received. A senior manager external to the service and an external quality team undertook regular monthly audits. However, medicines audits were not effective.

The registered provider was working towards completion of an action plan developed following a CCG clinical quality assessment audit.

Pavillion Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 27 May 2015, 2 June 2015 and 5 June 2015. Our visits on 27 May 2015 and 2 June 2015 were unannounced. Our visit on 5 June 2015 was announced. The inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the home. We also contacted the local authority commissioners for the service, the local healthwatch and the clinical commissioning group (CCG).

We spoke with nine people who used the service, four family members and a community matron. We also spoke with the registered manager and five members of care staff. We observed how staff interacted with people and looked at a range of care records which included care records for six of the 57 people who used the service, medication records for 57 people and recruitment records for five staff.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

Inadequate

Is the service safe?

Our findings

Medicines records did not support the proper and safe administration of medicines. We viewed the Medicines Administration Records (MARs) for 57 people. We saw MARs were not always clearly and accurately completed. The NICE guidelines 'Managing medicines in care homes' states with respect to medicines record keeping that 'Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process set out in the care home medicines policy (see recommendation 1.1.2).' We viewed the registered provider's 'Administration of medication policy version 2.0 dated 16/01/2014.' This stated, 'In all Embrace Services, medicines will be administered in a safe and professional manner, by appropriately trained staff, ensuring that accurate records are maintained.'

We found staff were not always following these guidelines. We found people were at risk of not receiving their medicines safely because records did not accurately account for all medicines administered to people. For example, we saw there were signatures on the MAR for five people to confirm medicines had been administered. When we checked each person's blister pack, we found the medicines were still sealed within the pack meaning they hadn't actually been given. For two people, we found medicines due for administration for a future date had been already been removed from the blister pack. For another person, we saw medicines that had been refused were missing from the person's blister pack. Staff we spoke with were unable to account for these missing medicines.

We viewed 57 people's MARs for the period 20 April 2015 to 17 May 2015. We found some of the MARs were inaccurate and incomplete. For example, we found there were gaps on the MAR for five people. This was because care staff had not signed to confirm that some medicines had been administered or not added a non-administration code when they hadn't been given.

We found the registered provider had regular systems of medicines checks. These checks comprised of daily, weekly and monthly medicines audits. We viewed records which showed the daily checks had been carried out consistently but had not been effective in identifying any concerns with medicines records. Weekly medicines audits had not been done consistently. For example, there was no evidence of weekly medicines checks for 1 and 8 May 2015. Those that had been completed had also failed to identify any concerns with medicines records.

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

People told us they felt safe living at the home. One person said, "It's just like being at home, but without the housework and cooking, I feel safe here." We found the provider's approach to risk management was inconsistent. We found in some instances that specific 'Risk enablement assessments' had been carried out for specific situations. For example, one person had an assessment in place because they were at risk of social isolation if not engaged. This assessment provided details of strategies to manage this risk. However, we found specific assessments had not been undertaken in some other potentially risky situations.

Staff had a good understanding of safeguarding. They could confidently tell us about various types of abuse and warning signs to look out for. Staff knew how to report concerns. One staff member said "I would go straight to the manager." Staff were also aware of the registered provider's whistle blowing procedure. All of the staff we spoke with said they would have no hesitation using the whistle blowing procedure if they needed to. They also confirmed they had no reason to use it so far. One staff member said, "We have got to do it [report concerns]." Another staff member said, "Yes, I would do it [report concerns]."

We received mixed reviews from people and family members about staffing levels in the home. One person said, "I think they need more staff, we don't get out on the bus as often as we should, it could be better." One family member said, "I think they all know what they are doing, but I think sometimes they are very short staffed." Another family member said, "There seems to be a lot of agency staff."

Most staff members we spoke with told there were enough staff to meet people's needs. Another staff member said, "I have not seen any problems [with staffing levels]." Another staff member, when asked whether there were enough staff, said, "Depends, it can be good or bad." Another staff member said staffing levels, "Were adequate at the moment." Another staff member told us, "People are not left. It is a struggle but we get round everybody. One extra staff member would make a big difference."

Inadequate

Is the service safe?

We visited the home on an evening to assess the staffing levels. We spoke with staff working the night shift. The nurse on duty said. "I feel there are enough staff. It works, it is done on risk based approach." Another staff member told us, "Night-time staffing levels are okay." Another staff member said there, "Should be more, there should be another carer on. Another staff member said, "Not enough staff, I am waiting for staff to help get people to bed.

Staff told us the new registered manager was changing how staff were deployed across the home. One staff member said this was, "Better because we now get to know the resident personally." We saw the registered manager regularly reviewed staffing levels to ensure there were enough staff to meet people's needs. The registered manager used a specific tool, which considered people's dependency levels when calculating minimum staffing levels. We saw the outcome from this analysis was that there was enough staff employed to meet people's needs. However, the tool was limited in its effectiveness, as it didn't take into consideration the layout of the building, night time staffing levels in isolation or busy times throughout the day.

The provider had recruitment and selection procedures to check new staff were suitable to care for vulnerable adults. We viewed the recruitment records for five staff. We found the provider had requested and received references, including one from their most recent employment. A disclosure and barring service (DBS) check had been carried out before confirming any staff appointments.

These checks were carried out to ensure people did not have any criminal convictions that may prevent them from working with vulnerable people. We spoke with a new member of staff who described their recent experience of the recruitment procedure. They told us they had completed an application form and attended for an interview with the registered manager.

The registered provider carried out a range of health and safety checks to ensure people's safety. These included checks on the premises and equipment, checks of fire safety, window restrictors, specialist moving and handling equipment, electrical and gas safety. We viewed the records of these checks and found these were up to date. Risk assessments were undertaken when required and action taken to help keep people safe. For example, a fire risk assessment had been carried within the last 12 months. The assessment had identified that a designated area was required for charging specialist moving equipment. We found the registered provider had responded to this recommendation and had identified an appropriate area.

There were systems in place to respond to emergency situations. The registered provider had developed a business continuity plan. Each person using the service had a personal emergency evacuation plan (PEEP). This provided guidance to staff about people's care and support needs in an emergency. We observed that the home was spacious, clean and bright. We did not notice any unpleasant odours as we walked around the home.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals. For example, we found the provider was not always following the requirements of the legislation. We found the registered provider had taken action to deter two people from leaving the home. Although this had been done to keep the people safe, there was no record of a MCA assessment and 'best interest' decision having been made. The registered manager confirmed the necessary assessments were not in each person's care records and accepted these assessments should have been done.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been assessed to establish whether a DoLS authorisation was required. We found applications had been submitted to the local authority for approval. These applications had been made in people's best interests following a MCA assessment. Staff we spoke with showed a good understanding of MCA and DoLS. They were able to describe their responsibilities under MCA. They were also able to tell us about the individual support people using the service needed to make decisions. For example, staff described how they supported people to make day to day choices such as what clothes they wanted to wear and meal choices. They described how they would show people items of clothing or pictures of plated meals to help them make their choice.

People were asked to give their consent before receiving any care. Staff said they would, "Always ask them first." They said they would respect people's decision. If a person refused, staff said they would record the refusal, talk to the person about their decision and try again later. We observed staff respected people's right to refuse. For instance, when one person had finished their meal we heard a staff member say, "Do you want to come and get a comfy seat?" The person responded, "No." The staff member said that was, "Alright." The person then stayed in the dining room as they had chosen.

Some people using the service displayed behaviours that challenged others. Staff demonstrated a good understanding of the needs of these people. They could give examples of strategies they used to support people when they were anxious or distressed. For example, various diversion techniques involving music and dancing. Staff told us they would refer to care plans which contained detailed strategies for each person. We observed how a staff member responded to behaviours that challenge over the lunch-time period. We saw them discreetly intervene to support one person into the lounge after eating their lunch to have quiet time. This was because they were becoming increasingly anxious. Shortly afterwards the same staff member supported the person back to their table to have dessert. The staff member explained, "This is part of [person's name] behaviour. I usually take [the person] into the lounge and then bring [the person] back for dessert." The person was then offered a choice of dessert, which they then ate.

Staff were well supported to carry out their caring role. One staff member said they were, "Fully supported. I can go the nurse, clinical lead or manager. There is always somebody to turn to." A new member of staff said, "The registered manager seems to be approachable." Another staff member said, "The manager gives you full support." Another staff member said the registered manager was, "Very fair and gives you full support. If you need anything she will try and get it." Staff were provided with the training they needed to fulfil their caring role. Compliance with training was monitored regularly and reported to the registered manager. Records showed most staff were up to date with training the provider had identified as essential, with the exception of nutrition and hydration training. For example, over 90% of staff had up to date moving and handling and food hygiene training. However, only 29% of support staff had completed nutrition and hydration training.

We carried out observations in both the upstairs and downstairs dining rooms to help us understand whether people had a pleasant lunch-time experience. We saw a pictorial menu was displayed on the wall. This showed the meal choices were 'Roast Chicken' or 'Roast Beef' with vegetables or 'Cold Meat Salad.' This did not match the laminated table menus which stated 'Steak and leek pudding' with vegetables. However, when the meal arrived people could choose from either Roast Chicken or Ham Salad. We asked a member of the kitchen staff why people

Requires improvement

Is the service effective?

weren't offered Roast Beef. They said, "We didn't have any Roast Beef." This meant people were given conflicting and confusing information about which meals were available to them to choose from.

We found in both dining rooms people were seated a long time before receiving their lunch. For example, in the downstairs dining room people were sat waiting for 20 minutes before their lunch arrived. In the upstairs dining room one person was sat for 30 minutes before their meal arrived. We saw people became increasingly agitated. For instance, one person was pouring salt on the table from the salt cellar. At one point the person also knocked over a glass of water. We heard the person shout out on two occasions, "I don't know why they are keeping us so long." Staff brought another person to the table on three occasions, despite a senior care worker advising, [Person's name] won't sit down until the food has arrived."

We found the tables were set before people arrived including placemats, cutlery, crockery and condiments. Where people used specialist cutlery or crockery this was already placed on the table ready for them to use. Staff offered people a cold drink and a choice of meal. The meals offered to people looked appetising, apart from people requiring a pureed diet. We saw that in both dining rooms people were fed a pureed chicken dinner. All of the contents of the meal had been pureed together. The puree resembled a greyish/brown liquid. This meant people did not have the opportunity to experience the different appearance and tastes of the individual parts of their meal.

Staff were kind and considerate towards people. They ensured people received the support they needed to eat and drink. For example, staff asked if people wanted help cutting up their meals. Most of the interactions we observed between people and staff were positive. The staff worked well as a team and the care workers assisting people interacted well with the residents. For instance, two people required one to one assistance from staff to eat and drink. Staff were patient when supporting people and gave them the time they needed so they weren't rushed. Although one of these people received support from three different staff members. Although all staff members were kind towards the person it meant they did not receive interrupted and consistent support from one staff member. One person said to a staff member they wanted, "Just a small plate." Before leaving their meal we heard the staff member check with the person they had the amount they wanted by asking, "Is that enough?"

People were supported to meet their health care needs. We saw from viewing care records people had regular access to healthcare professionals. For example, some people had been referred to a dietitian due to experiencing unexpected weight loss. Other people had been referred to a speech and language therapist due to swallowing difficulties. We found from viewing care records that these people had been assessed. Advice and guidance had been provided to staff following the assessment. During our inspection we spoke with a visiting community nurse. They told us they had seen recent improvements in the care people received. The community nurse said staff now recognised triggers and made appropriate referrals for advice and guidance. This meant staff were now able to care for more complex people in the home rather than admit them to hospital.

We recommend the service considers current guidance on the preparation and presentation of 'special diets' and takes action to update their practice accordingly.

Good

Is the service caring?

Our findings

People using the service and family members gave us some positive feedback about the care delivered at the home. One person said, “They look after you well here.” Another person said, “They don’t mind how much they do for you here, I like coming here.” One family member said, “[My relative] chose this home for respite care, and it was so good this is [my relative’s] second time here, [my relative] likes it here.” Another family member said, “[My relative] is as happy as I can expect, I would say it is satisfactory.” Another family member said, “[My relative] is always clean, good food and [my relative’s] clothes are good.”

People and family members said staff were kind and caring towards their relatives. One person said, “The staff are good here.” One family member told us, “The carers know [my relative], they are very caring, and they definitely know [my relative] very well.” We observed many examples of staff displaying kindness towards people. For instance, one person said, “I am cold. I am frozen.” A staff member asked the person, “Do you want a blanket.” They then went on to ask the person sat next to the person who was cold if they would also like a blanket. Both people said they would. The staff member went to get blankets and returned shortly after with them. The staff showed the two people a selection of blankets and asked them to choose which one they would like. They asked one person, “Where do you want this [blanket], over your legs.” A staff member saw that one person was yawning. They said to the person, “Are you tired [person’s name]. Would you like to go to bed?” To which the person replied no.

We carried out a specific observation in the first floor lounge area using SOFI. We saw that throughout the 40 minutes of our observation people received regular interaction from staff. We saw staff were kind, caring and considerate towards people. For example, staff checked whether people needed any assistance. Where people requested help, such as requesting pain killers, staff responded to their needs quickly. We observed staff assisting one person to walk into the lounge and sit down. Staff were patient and allowed the person the time they needed. They explained to them what was happening and gave clear instructions to help the person mobilise safely. Staff were present in the lounge area throughout our observations to check on people’s safety. We saw that one person was anxious and worried. Staff were discreet in supporting the person through distraction. They showed the person a birthday card they had received, offered re-assurance and chatted with them.

Staff had a good understanding of the importance of maintaining people’s dignity and respect. We observed staff supporting people to maintain their dignity. For example, staff asked one person who was pacing up and down in the lounge if they would like to use the toilet. When the person replied no, the staff member suggested they sit and listen to some music. We heard another staff ask reassuringly, “[Person’s name] can I wash your hands as they are covered in chocolate.” Staff we spoke with described how they delivered care whilst at the same time ensuring people were treated with dignity and respect. They gave examples of how they aimed to achieve this. For example, locking doors and closing curtains when supporting people with personal care, offering re-assurance, explaining what was happening and checking people had understood.

People who wanted to were able to follow their religious beliefs. One staff member said, “A minister from the church calls on a regular basis, people who want to participate are encouraged to do so.” They went on to say this was for all religious denominations. One person told us they were very happy living at the home. They said they had been to the dining room, had a walk along the corridor and seen their friends. They commented they had, “Just had a lovely meal, I have a good room and now I am going to watch TV, read the paper and have a little sleep.”

Staff we spoke with had a very clear view about what the home did best. Their comments included, “I would put my mam here. The care is absolutely fantastic in here”, “I can’t fault it”, “[Care is] person-centred, we do things their way”, and, “We treat people as a person.”

Requires improvement

Is the service responsive?

Our findings

When people were admitted into the home staff spent took time to collect information about each person. In this way staff could access information to help them better understand the people in their care. Each person had a document called 'This is me' which included important information about the person's 'life history' and their preferences. For example, details of close family members, previous employment and significant events in the person's life. 'My Day' provided details of what was important for people at particular times of the day. For instance, one person had a preferred time for getting up and preferred to spend some time in the evening in their room reading or listening to music. People had their needs assessed on admission into the home. This assessment along with the other information gathered on admission was used to develop personalised care plans.

Care plans we viewed were not always personalised and detailed. For example, one person had a 'Concerning behaviour support plan' which identified strategies to support the person when they were anxious. Strategies identified were general and did not provide details of the individualised care the person needed. For example, strategies identified were to reassure the person and provide one to one time. However, the care plan did not provide details of how to re-assure the person or what worked best during one to one time. Care plans were in the process of being updated following the recruitment of a new registered manager. This was to ensure they were up to date, person-centred and contained enough information to ensure people received consistent care. Care plans we viewed had been reviewed regularly. However, the record of the review gave a brief summary for each care plan and prompted staff to indicate whether the care plan had been updated.

We received mixed reviews about the activities available for people to take part in. One person said, "We don't get out on the bus as often as we should." One family member said, "I often come in during the evening and there is not much going on, they are all just sitting around." We also observed when we visited on the evening that for most people there were no activities to engage people. However, we did observe that one person was helping staff with washing dishes. They told us they were enjoying helping out. At the time of our inspection the activity programme was in a transitional stage. Two activity co-ordinators were due to leave imminently. One new activity co-ordinators had just started with a further co-ordinator due to start. The registered manager told us about plans to improve the activities available to people, particularly those living with dementia. There were also plans to increase the availability of activities to evenings and weekends and to improve the use of the mini-bus.

We observed the activities co-ordinator running a new initiative called 'Oomph.' This was a lively singing and exercise based activity. The activity co-ordinator had engaged 12 people in participating. We saw people were gently encouraged to take part with the majority of people either singing or exercising. We saw the activity co-ordinator created a stimulating event appropriate for the people taking part.

People and family members knew how to complain if they were unhappy. They told us they would be comfortable and confident going to the manager if they had a complaint. People and family members said they felt concerns would be dealt with. One family member said, "I have not had the need to complain, but I would be very happy to talk to the manager if I needed to raise any issues." We found there had been one recent complaint about the home. This had been dealt with and action taken to prevent the situation happening again.

There were opportunities for people and family members to give their views about the care delivered at the home. 'Resident's meetings were held every month. We viewed the minutes from recent meetings. We saw people had provided positive feedback about activities held in the home, including 'oomph' and sing-a-longs. People suggested they would like to have more entertainers Family members told us they had attended meetings.

People and family members had been consulted in January 2015 about the quality of the care delivered. 62 surveys had been sent with 23 returned. We saw the results of the last survey had been analysed and actions identified to improve the quality of care. These included regular reviews involving family members, recruiting to existing staff vacancies and three monthly resident's meetings. We found most people were happy with their relative's care. For example, 86% and 82% said they were happy with the level of care given in relation to their relative's mental health and spiritual care respectively. Fewer family

Requires improvement

Is the service responsive?

members (69%) were happy with their relative's social care. Family members suggested areas for improvement such as increasing activities, environmental improvements, better communication and monitoring of medicines.

We recommend the service considers current guidance on meaningful activities for people living with dementia and takes action to update their practice accordingly.

Requires improvement

Is the service well-led?

Our findings

The home had a new registered manager, who had been registered with the Care Quality Commission since May 2015. We received positive feedback about the new registered manager from family members, staff and a visiting health professional. One staff member said, "The new manager is making a lot of changes for the better, she is freshening the place up. I am pleased that she has taken over, I think it is for the better." Another staff member said, "I love working here, we get a lot of support from management and I have been encouraged to participate in further training." A new member of staff said, "I am settling in OK the manager is very supportive." The visiting healthcare professional said the registered manager was pro-active in dealing with situations which arise.

Staff told us the home had a good atmosphere. One staff member said, "Morale seems okay, I have not seen a sad face. The staff are friendly and approachable." One family member commented, "Staff are all very approachable, they contact me at home if they have any issues with [my relative]."

The registered provider had systems in place to assess the quality of the care people received. The registered manager completed regular audits including a meal-time audit, care plan audits and an analysis of incidents and accidents. Action was taken to follow some audits to address areas for concern. For example, changes had been made to ensure medicines weren't administered during meal-times so that people weren't disturbed and action taken following accidents to help keep people safe. This included accessing medical assistance and referring people to the 'falls team.'

However, although the registered provider carried out daily, weekly and monthly checks which looked at medicines records, these were not effective in ensuring the quality of medicines records was maintained. These checks had not been successful in ensuring appropriate action was taken to identify and investigate issues with medicines records. During our inspection we found inaccurate records and gaps in signatures on people's MARs which had not been identified and investigated.

A senior manager external to the service and an external quality team undertook regular monthly audits. We viewed the most recent audits which had been carried out in March 2015 and April 2015 respectively. We saw the senior manager's audit prompted the manger to 'include the initials of at least two people spoken with.' However, there was no records of people's feedback captured on the completed audit template. The audit also included a check on safeguarding concerns, complaints, health and safety and the environment. The quality team audit we viewed from April 2015 identified similar concerns with the effectiveness of medicines audits to those we found.

The registered provider was working towards completion of an action plan developed in March 2015 following a CCG clinical quality assessment audit. The plan was detailed and included action across a range of areas including care plans, MCA assessments, hand hygiene, infection control involving people and relatives. Compliance with the action plan was being monitored through the monthly senior manager's visits. It was difficult assess from viewing the action plan when compliance would be achieved. This was because most of the actions identified did not have a specific timescale attached and were mostly 'on-going.'

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who use services were not protected against the risks associated with unsafe or unsuitable care and treatment because the registered provider was not following the requirements of the Mental Capacity Act (2005) where people were unable to consent to their care because they lack capacity to so. Regulation 11 (3).

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the continuing safe management of medicines. Regulation 12 (2) (g).