Joseph Rowntree Housing Trust

Olive Lodge

Inspection report

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Date of inspection visit: 24th and 27th April 2015
Date of publication: 08/07/2015

Ratings

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

Overall summary

We inspected Olive Lodge on the 24 April 2015 this visit was unannounced. We then visited on the 27 April 2015 which was announced. Our last inspection took place in April 2014 where we identified a breach of legal requirements in Regulation 20 HSCA 2008(regulated activities) Records. An action plan was implemented at the home and there were signs on inspection that the service had made improvements in this area.

Olive Lodge is a 40 bedded purpose built care home close to Horsforth Town Street in Leeds. The home has 36 single occupancy rooms and three apartments, all of which are en-suite and have a french door leading to a private balcony or patio.

The home had a registered manager in place, but was not at the home on both the days of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People we spoke with told us they felt safe living at the home. We saw risks to people were managed appropriately whilst ensuring people were safe and given their freedom. We spoke with six staff who told us they understood how to recognise and report any abuse. Training records showed staff were trained in safeguarding.

Staffing levels were sufficient which meant people were supported with their care and enabled to pursue interests of their choice in the home and out in the community.

No-one at the home was subject to the Deprivation of Liberty Safeguards (DoLS). Staff had been trained and had a basic understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We spoke to staff about Mental Capacity, but staff were vague in their responses to this. However, we found that one person at the home had been refusing their medicines and the home had not taken appropriate action with regard to this.

We saw that medicines were not always managed safely at the home. We looked at medication administration records (MAR) which showed people were not always receiving their medicines when they needed them.

People we spoke with told us they were mostly happy living at the home

We saw staff had developed good relationships with people and were kind and caring in their approach. People were given choices in their daily routines and their privacy and dignity were respected. People were encouraged to be as independent as possible in all aspects of their lives.

People's nutritional needs were met and they received additional health care support when required.

People in the home told us that there had been recent failings in the nurse call system in place at the home. We were notified of this and the deputy manager had arranged the call system to be fixed. A thorough risk assessment had been carried out that indicated that most people were able to summon help using the internal telephone system in their room. To support those people who were unable to use the telephone an additional member of staff was on duty and documented 30 minute walk round checks were carried out. We spoke with people about the response times when they used the nurse call system to summon assistance from staff. One person's relative told us their relative had to wait 20 minutes to be taken to the toilet.

We were shown records which showed a number of falls had occurred at the home. We spoke with the deputy manager and the care operations manager who told us there had been a number of referrals made to the falls team. They said some people now had sensors in place in their rooms which would alert staff to their movements.

From our observations it was clear the staff knew people well. We saw that staff were trained in supporting the people in the home. Staff told us they were supported and supervised in their roles. Supervision meetings should have taken place every two to three months however, we found evidence which showed that this was not being done as planned.

We saw there was evidence in place to show the home had made improvements to the care plans. The care plans were focused around the individual person and were person centred.

Records we looked at showed there were some systems in place to assess and monitor the quality of the service and the focus was on continuous improvement. There was good leadership at the service in the registered manager's absence which promoted an open culture.

We saw there was a complaints procedure in place which was displayed in the home. People we spoke with told us they knew how to complain. The home had received complaints and these were dealt with promptly.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found that appropriate procedures were not in place regarding the management of medicines.

The staff had a good knowledge of safeguarding procedures and how to put these into practice.

The environmental checks were in place and carried out regularly but the call bells were not working at the time of our visit.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the service was not meeting the legal requirements relating to

Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act 2005.

Mandatory training had being completed in the home by all staff on induction.

People's health care needs were being met in the home by visits from their local GP and chiropodist.

Supervisions with staff were not being completed as the homes policy indicated they should be.

Is the service caring?

Requires Improvement

The service was not always caring.

The majority of people we spoke with told us that staff spoke to them in a kind and respectful manner, however some people said that they found staff patronising at times.

We observed staff providing people with explanations about what they were doing whilst providing care to them. It was clear from our observations that the staff knew people well.

We observed people looked well cared for. Peoples family told us they felt that there family members were being well cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place for the people in the home.

Some people told us they were waiting for long periods of time for assistance due to the call system not working.

People were able to make choices for themselves.

Summary of findings

Is the service well-led?

The service was not always well led

People were put at risk at risk because systems for monitoring quality of medicines were not effective.

The registered manager was not managing the day to day running of the home at the time of our inspection. The deputy manager was undertaking this role with support from senior managers in the organisation.

Staff we spoke with told us they felt supported by the deputy manager and found them to be approachable if they had any concerns.

The home had mechanisms in place which allowed people using the service and their relatives to provide feedback on the service provision.

Requires Improvement

Olive Lodge

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 24 April 2015 this visit was unannounced. We returned to the home on 27 April 2015, this visit was announced. At the time of our inspection there were 36 people living at the home. On the first day the inspection team consisted of two adult social care Inspectors and an expert by experience an expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day two adult social care inspectors returned to the service.

Before the inspection we reviewed all the information held about the home. The provider had not been asked to provide a provider information return (PIR). This is a document that provides relevant up to date information about the home that is provided by the manager or owner of the home to the Care Quality Commission.

During the Inspection we spoke to eight people who lived at the home, two visiting relatives and six staff. We also spoke to the deputy manager who was providing managerial support to the home at the time of our inspection. On the second day of our visit we also spoke to the deputy head of care operations.

We used a number of different methods to help us understand the experiences of the people in the home. We spent time observing care practices in the home and staff interactions with people. We observed meal times taking place and activities being carried out in the communal areas of the home. We spoke to a number of people in their bedrooms and also in the communal areas of the home. We looked at the environment of the home which included the outside space for the people to use. We looked at documents and records that related to peoples care, and the management of the home such as training records, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We spoke to people and asked if they felt safe living at the home. They told us that staff were gentle when providing care and that they had never been hurt or roughly treated. They said they felt secure in the home and were not worried or anxious about being hurt. People also told us,

"I always feel the girls are well trained, I'm confident they know what they are doing." Another person told us, "Oh yes I feel safe here, all the doors and windows are locked at night and curtains drawn, they come round and inspect everything is secure."

We saw the environment of the home appeared well maintained and we saw documentation which showed that weekly checks were carried out on the fire alarm system, monthly emergency lighting checks and fire extinguishers, and weekly water temperature within the home. The home was well decorated, clean and spacious with a homely feel. We looked in people's bedrooms which we saw were comfortable and clean with good quality furniture and fittings. The rooms were furnished with the peoples own furniture and personal effects. The bathrooms located on each floor were clean and hygienic. We looked at records which showed that if repairs were required to the environment, these were recorded and when completed they were signed to show the action had been carried out. The manager told us they had a dedicated maintenance person who was based at the home. This meant people were cared for in a suitably maintained environment.

Staff we spoke with had a good understanding and knowledge of safeguarding. Staff told us they knew people well and would be able to recognise signs which may indicate possible abuse or neglect. Staff told us they understood the procedure to follow to pass on any concerns to senior staff or the manager of the home and felt these would be dealt with appropriately. Staff were clear about their responsibility to report concerns and was aware of whistleblowing procedures and how to use them. There was an up to date safeguarding policy in place. Staff we spoke with told us that they had attended safeguarding training. Safeguarding training was completed on induction and then staff completed refresher training every year. The deputy manager showed us an overview of staff training which showed 82% of staff had completed safeguarding refresher training within the last 12 months. Further training was booked for May and June 2015. This showed the service had plans in place to ensure all staff had the training they required for their role.

We looked in people's care records and saw where risks had been identified for the person, there were risks assessments in place to ensure these risks were managed. For example, care records showed assessments were carried out in relation to mobility, nutrition and medication. These identified hazards that people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm.

We found that there were a number of issues in regards to the systems in place for the management of medicines in the home. This included storage, administration, records, guidance and quality of information available for staff regarding medicines. We looked at medication records (MAR) for four people in the home and we saw there were a large number of gaps on all four records. On one person's MAR records we saw a staff member had signed on the MAR records to say the person had refused their medication. They had then signed again which meant it was unclear if the person had received their medication. We spoke with the staff member about this and they said they had done this as person had refused their medication. They had then reoffered the person their medication later in the day which they had taken. The staff member told us that they were unclear about how to record this on the MAR.

The MAR's in use were printed by the dispensing pharmacy but we saw they did not include the times that people's medicines should be given. We saw that staff had handwritten these onto the MAR. This consisted of 'AM, T and N' meaning morning, teatime and night. One staff member told us people's morning medications were administered between 8am till 11.30am. We spoke with a staff member and the deputy manager who agreed the guidance regarding times for administration was not clear.

There was a lack of information on the MAR's for staff to follow. The directions on one person's MAR we stated "as per psychiatrist". We spoke to the deputy manager about what this meant and they told us that this information would be in the person's' medication support plan'. We

looked at this document and found no guidance for staff to follow when administering this medication. This meant the person was at risk of not receiving their medicines when they needed them.

We saw people were prescribed medication 'as required' (when they needed it). We were unable to find any guidance in place for staff to follow as to when the person would need this medication. For example, any signs and symptoms the person would exhibit when they needed the medication. We also found there was a lack of information available for staff regarding the side effects of the medication they were administering to people in the home .This meant staff were not informed of any adverse reactions people may experience after taking any medication.

We were told people at the home had their medication in a lockable cabinet in their bedrooms and only the staff trained to administer medicines had access to the keys. We were told weekly checks of the locked cupboards were carried out of medication by senior staff on duty. We saw records for these checks and saw they were not completed consistently. We saw staff had written on the documents when the checks had not been completed "sorry very busy," "very busy" and also "did not have time."

We checked the medicines stored in the lockable cabinets in people's rooms and found in some cases people did not have the correct number of medicines in place. We also found there were medicines which were no longer prescribed to the person. This put people at risk of receiving medicines which were not prescribed for them. In one person's locked cabinet we found two bottles of eye drop medication. The directions on the label stated one of these were to go in the person's right eye only, however we found this medication had not been placed in the correct box and the label could not easily be seen due to this been twisted in the screw cap. This meant the person was at risk of not receiving medicines as per prescription required.

We checked an area of the home were stock medication was stored. This was a locked cupboard which only certain staff on duty had access to. We found open plastic containers were used and they contained a number of medicines. We spoke with staff and the deputy manager and they told us there were no records available to show what medication was being kept in stock. We found there were 874 Paracetamol tablets, 212 Laxido sachets and 318 Calceos tablets in the cupboard amongst many other medicines. We also found medicines dated 13th January 2015 another was 25th July 2014, 12th November 2014 and 18th September 2014 when they were dispensed from the pharmacy. None of these medicines had been used for the people in the home as prescribed. This meant there was a lack of systems in place to monitor and record the level of medication in the home.

All the above examples illustrate a breach of Regulation 12(2) (b) (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were not adequate systems in place to monitor and record the medication in the home.

We looked at the recruitment records for three staff. We found recruitment practices were robust and each staff member had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable groups. Each record showed detail of the person's application, interview and references which had been sought. We spoke with three staff members who confirmed this recruitment process had been followed. This showed that staff were being properly checked to make sure they were suitable to work with vulnerable adults.

We were shown records which showed a number of falls had occurred at the home between 2 January 2015 and 17 March 2015. These were 17 falls in January 2015, 25 falls in February 2015 and 13 falls up to 17 March 2015. We saw the majority of the falls had occurred in people's bedrooms and only three of the people who had fallen were assessed as requiring support with mobilising. We spoke with the deputy manager and the care operations manager who told us there had been a number of referrals made to the falls team. They said some people now had sensors in place in their rooms which would alert staff to their movements. We did not see improvement action plans in place which had been cross-referenced with the individual risk assessments and care plans, to minimise the risk of re-occurrence. The deputy manager told us they did not monitor incidents for any patterns or trends. This showed that an effective system was not in place to monitor incident systems and that the service did not learn from incidents, to protect people from harm. All the above examples illustrate a breach of Regulation 12(2) (b) (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

Is the service safe?

At the time of our inspection the registered manager was absent from the service. The deputy manager was providing managerial cover and a deputy of care operations was supporting the running of the home. There were six care staff on duty at the home through the day 7.30am-3pm and five staff on an evening 2.30pm-10.00pm. There were two night staff on shift which also consisted of one senior carer. There were ranges of support staff on duty which included three domestics and also one laundry staff member who provided cover seven days a week. The home also had a chef and one kitchen assistant on shift. A maintenance person works 15 hours per week. We felt that the home had adequate staff in place to support the service.

People in the home told us that there had been recent failings in the nurse call system in place at the home. We were notified of this and the deputy manager had arranged the call system to be fixed. A thorough risk assessment had been carried out that indicated that most people were able to summon help using the internal telephone system in their room. To support those people who were unable to use the telephone an additional member of staff was on duty and documented 30 minute walk round checks were carried out.' We spoke with people about the response times when they used the nurse call system to summon assistance from staff. One person's relative told us their relative had to wait 20 minutes to be taken to the toilet. Feedback from people was mixed and most people told us staff either came very soon or within up to half an hour which people seemed to tolerate.. They said they knew "staff were so busy." One staff member told us that the nurse call system had been down for a week and they were waiting for batteries to be replaced.

We spoke to the deputy manager about this and they told us they had plans in place to manage the situation in the interim with extra staff on duty at night. The deputy manager said that through the day there were more staff around. This was specifically to check on people to ensure their safety in the home. The call bell system had been reported as a matter of urgency, contractors had arranged to come out on 30 April to complete the repairs. People we spoke to also confirmed that this was taking place. Our observations and discussions with people and staff showed there was sufficient staff on duty to meet people's needs during the day and night. The manager has told us that they have had the call system repaired since our inspection.

Requires Improvement

Is the service effective?

Our findings

We asked the people about the continuity of staff and if this affected the quality of their care. We were told that due to shift working the carers were not always the same but this was not highlighted by anyone as an issue. Comments were, "All staff are very good." "I always feel comfortable when showering, the girls are well trained and I feel confident they know what they are doing."

Staff we spoke with told us they received the training and support they required to carry out their roles. They also told us they all worked as a team in supporting each other as they care about the people who they support. Staff said they received supervisions and appraisals but were not always as often as they should have been receiving them. This was evident in the staff records we looked at. We were told that supervisions should be carried out every two – three months. Records show that some staff supervisions were taking place every two months while other staff supervisions were not as frequent. This meant that some staff did not have the chance to discuss issues or concerns at regular supervisions. The staff files we looked at all had received a yearly appraisal, which gave staff the opportunity to discuss their training needs and requirements. The deputy stated that they were going to look at supervisions for all staff and ensure that supervisions for all staff were completed in line with the home policy.

Staff were able to describe clearly the needs of the people they supported and knew how these needs should be met. The training matrix we looked at showed the training staff had completed. This included first aid, infection control, fire safety, and food hygiene, medication awareness, safeguarding and moving and handling. The staff files showed that staff had completed training, but in some cases these were out of date. The deputy manager stated that she was working on staff completing all training over the next couple of months to ensure that all staff were up to date.

We were told that one member of staff were due to complete 'champion's computer' training so that they could support staff to undertake E Learning which was being introduced.

We spoke with a staff member who told us about their induction. They said it had been very useful and had prepared them well for their role. They told us their induction had included spending time shadowing more experienced staff and also time to have a look through care records. They also said this had given them the opportunity to get to know what people's needs were and how to support them.

Staff told us people were supported with accessing health care services such as GPs, dentists and chiropodists. Records also showed people using the service received additional support when required for meeting their care and treatment needs.

People had sufficient amounts to eat and drink. We observed lunch being served to people in the home and saw people who required support with eating their meal were assisted by staff in a dignified and respectful manner. When we observed the meal time we feel that more could have been done to help one person who was partially sighted. The carer did help the person to navigate the food on their plate but we noted later that only the peas had been eaten. When we left the room the person was sitting at the dining table with most of the food left cold on their plate. After speaking to the staff they said that they would have recorded if people did not eat an appropriate amount of food and staff stated that they would record this for the staff on shift so that people could be offered another choice or recorded that they only ate a small amount at meal time, this would be picked up at the next meal.

The meals at the home were provided in peoples own rooms if they wanted or in the dining room. A cooked breakfast was on offer in the morning with a hot lunch and a selection of soups, salads or sandwiches for tea. We observed the lunch where approximately 30 people ate in the dining room. The room was bright and airy with tables set nicely with cloths, napkins and flowers. There was a sociable and relaxed atmosphere in the room with conversation at the tables between some of the people and friendly banter with the staff. There was a three course meal provided with a fish or a vegetarian option on the menu. The food looked hot and appetising and most people seemed to enjoy their meal. Comments about the food were positive: "well fed, top priority", "The food is very good here, beautifully presented." "The food has improved of late, more things that I like." "Choice of menu, fresh, tasty, chef very nice, very nice indeed."

One relative was impressed with the care their relative received and the awareness of all the staff of their

Is the service effective?

particular needs and how they had coped. They told us, My dad has not adapted well to living here, what stands out here is that the staff genuinely care; they all know my father and his situation. He was difficult and would not get showered but they have managed to get him into the shower. The staff are without criticism."

In relation to the liaison between relatives and staff we found this to be open and positive. They were friendly and familiar with the staff. We observed one visiting relative taking part in the afternoon activities. One person's relative told us, "The carers are always willing to offer assistance and to get a senior if I have a difficult question. They always get in touch if there is a problem." Another said, "I get on well with them and have no complaints about the staff here."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We were told by the deputy manager that no-one living in the home was subject to an authorised Deprivation of Liberty safeguard (DoLS). They said they had not identified people who were possibly at risk of being deprived of their liberty therefore; applications had not been made to the local authority.

The MCA (Mental Capacity Act 2005) is legislation designed to protect people who are unable to make decisions for them and to ensure that any decisions are made in people's best interests. The deputy manager told us none of the people living at the home had dementia and they were all able to make decisions about their care. They told us all of the people living at the home had the mental capacity to do this and there had been no assessments of anyone's mental capacity carried out. Staff training records we looked at showed all staff had completed mental capacity training within their induction.

During our discussions with staff we were told that one person had been refusing their medication on a regular basis. We asked the staff what they had done about this. They told us they knew the person well so would try to get them to take them at a later time or discuss the need for the medication to be taken. We asked the deputy manager if the person had the mental capacity to understand the implications of not taking their medication. The deputy manager told us they did not know. They told us they had not carried out an assessment of the person's mental capacity nor had they contacted the person's GP in relation to this.

On the second day of our inspection we discussed our concerns with the care operations manager who told us they would arrange for the person's GP to visit the home as soon as possible. This meant that the manager had incorrectly stated that no one required assessment of capacity at the home and consequently this person was not being reviewed appropriately in relation to the legal requirements of the MCA 2005. This example demonstrated that the deputy manager did not fully understand the application of this important legislation. These examples demonstrated the home was not meeting the requirements of the Mental Capacity Act 2005. This is a breach of Regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We observed staff interactions with people throughout the inspection and saw that all of the staff who worked at the home displayed warmth, kindness and compassion to each person they supported. Some of the people living at the home were able to tell us their views on the care they received. One person told us "The staff are friendly and kind." Another person told us, "All very good, very kind, some are kinder than others. I am very comfortable and enjoy living here. A further person told us, "Couldn't find fault, it's a good place to live, I'm very happy here. I would recommend it." People also gave us positive feedback about the care and support they receive from staff. One person said, "I wouldn't run the staff down they will do anything for me if I ask. I wouldn't like to move from here

We also received some negative comments from people in the home about staff approach. One person told us, "Some of the younger staff are patronising and don't have an understanding of older people. They speak in loud voices when I am not deaf!" Another person told us, "Sometimes staff can be a bit brusque but that is understandable they are busy." Another person said, "I understand they are under pressure to get things done but they can't appreciate what it feels like when you've managed your own life I told one of them she was a hard task master but I don't think she understood what I mean."

We spent time observing staff in communal areas and people's bedrooms. We saw staff appeared to work along together and support each other as a team. The home and the atmosphere appeared relaxed and friendly. We spoke with staff who told us, "We are busy supporting people here at the home but we work together as a team." Staff also told us, "We feel we provide good care to the people in the home."

We spoke to the relatives of two people during the inspection who told us they were happy with the care which was provided to their relative. One of the relatives told us they visited five times a week and they had never seen any signs of conflict. They said they thought the staff worked well as a team. They also commented that the domestic staff often helped the care staff out.

It was clear to us that staff knew people well and did not miss opportunities to engage with people. For example, on the first floor of the home a coffee morning was taking place and people who attended were sat in small groups and staff members were chatting and engaging throughout the activity. People appeared relaxed in staff company.

Staff were observed treating people with privacy and dignity during interactions with people which included care and support. For example, we saw staff knocking on people's doors before entering their rooms and also staff giving people time when supporting them with their mobility and personal care throughout the day.

When we looked around the home we saw people's bedrooms had been personalised and contained items such as family photographs and ornaments. We saw people looked well dressed and cared for. For example, people were wearing jewellery and had their hair combed. This indicated that staff had taken the time to support people with their personal care in a way which would promote their dignity

We looked at six peoples care records for evidence to show if people had been supported in making decisions regarding their end of life care. We found evidence which showed this had been carried out in only one of the care records. Having an end of life care plan in place increases the likelihood that the person who lives at the home has their wishes known and respected at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people and asked if they felt they were able to make choices about their lives and the care they received at the home. One person told us, "I'm able to choose what I do on a day to day basis. I'm lucky that I don't need as much support as some people. I am able to go out when I like, the door is not locked, and I can come and go as I please. I have my meals in my room sometimes; sometimes I use the dining room. There is always plenty going on to get involved in too. I also go to bed when I want to. They help me when I need it and when I don't they let me get on with it. I couldn't ask for a better place."

The home offered people the opportunity to develop skills and also a choice of activities they could participate in which reflected their hobbies and interests as recorded in their care plans. The home employed a dedicated activity coordinator and another carer who worked part time to support this. A wide ranging programme of activities was provided which included quizzes, a book club, arts and crafts, computer club, exercise class, film night and a book club. Regular outings were arranged and attendance rotated to give everyone an opportunity to go out. We saw the week before our inspection there had been a trip to a fish and chip café and another was planned for the coming week. We also saw there were plans for visits to the local pub for lunches.

All the people we spoke with told us they attended some of the activities with the book club being very popular amongst them. On the day of the inspection there was an exercise class in the morning and a quiz in the afternoon which we saw six people attended. Links were also in place with a local church and we were told some people attended lunch clubs, trips out and other activities. This showed the home was meeting the social needs of people who lived there.

During our inspection we were concerned as we spoke with staff and they told us one person had 'severe dementia', another staff member also told us the person had "some sort of dementia." The deputy manager told us this was incorrect and the person had a 'cognitive impairment.' We were concerned at the level of understanding displayed by staff at the home regarding the person's care needs. The deputy manager of the home was going to speak to the staff around this.

People had their needs assessed before they moved into the home. This ensured the home considered how they were able to meet the needs of people they were planning to admit to the home. We looked in the care records of three people and saw they contained a range of care and support plans which included daily living, personal care, night time support, communication, health/medical, medication and eating and drinking. All of the care plans we looked at were written in a person centred way which provided staff with clear guidance on how to meet the person's needs. For example, 'X (the person) like to have a commode at the side of their bed during the night. Please take this away in the morning' and 'Please remind me of any up and coming appointments I may have.' This showed people's care planning was individually tailored to meet their needs.

We saw each of the care records we looked at contained documents for the purpose of gathering information about the person and their life before they moved into the home. A life history document enables staff to understand and have insight into a person's background and experiences. We saw the majority of these had been completed however, in one of the care records we looked at; we saw some areas of the document had been left blank. For example, 'life changing experiences' 'My fondest memory' 'My favourite film' I am more of a morning or evening person' 'I like to spend time on my own or in a group' and the 'resident history' document were all blank. Had this been completed it would have helped care staff to know what was important to the person and helped them take account of this information when delivering their care.

In one of the care records we looked at we saw the person's relatives had been involved in completing a document regarding their life history. In the other three records we looked at we found that where people or their relatives could have signed documents regarding the person's care they had not, these spaces were blank. This meant that people's care records did not always accurately reflect the involvement of either the person or their relatives in the planning or review of care.

We spoke with people and asked if they felt they were able to make choices about their lives and the care they received at the home. One person told us, "I'm able to choose what I do on a day to day basis. I'm lucky that I don't need as much support as some people. I am able to go out when I like, the door is not locked, and I can come

Requires Improvement

Is the service responsive?

and go as I please. I have my meals in my room sometimes; sometimes I use the dining room. There is always plenty going on to get involved in too. I also go to bed when I want to. They help me when I need it and when I don't they let me get on with it. I couldn't ask for a better place."

We saw the home had a number of mechanisms in place which supported people living at the home and their relatives to provide feedback on the service provided to them. The deputy manager told us regular, monthly resident meetings were held at the home. We saw handwritten minutes from two meetings held in January and February 2015. These were difficult to read and did not provide a level of detail which showed the level of discussion which had taken place.

We looked at a satisfaction survey which had been carried out in 2014. The deputy manager told us these were done on an annual basis. The response rate to the survey was 42 per cent. We saw that people had responded to a range of questions under the heading of 'Safe, Effective, Caring, Responsive and Well led.' The majority of the feedback was positive and showed that people and their relatives would recommend the service to friends and family. The deputy manager had responded to complaints within the home in a timely manner, one person had complained about the lack of choice of food in the home. The deputy manager passed this information onto the senior management and the menus were changed accordingly to address the situation.

At the end of the survey the manager had been required to develop an action plan in response to comments made in the survey. They were regarding some people feeling that staff did not listen to their choices, some people did not feel involved in their care and others did not feel they were involved in the running of the service. The deputy manager told us the action plan had not been developed therefore, the issues raised had not been addressed. The deputy manager said that this would be looked into and an action plan completed to address any of the issues raised would be addressed in the home straight away.

We saw there was a complaints procedure in place which was displayed in the home. People we spoke with told us they knew how to complain. The home had received complaints and these were dealt with promptly.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post however; this person was not in charge of the day to day running of the home at the time of our inspection. The deputy manager was acting as manager of the home and was being supported by weekly visits from one of the care operations managers of the organisation. The deputy manager told us they felt well supported by the care operations manager who visited the home to work alongside them two days a week. They said, "if there has been anything I haven't known or needed to get hold of I have been really well supported by X (care operations manager). I know I can pick up the phone anytime really and they are always really helpful." Staff we spoke with told us there were around 10 staff members who had worked at the home since it opened 11 years ago which they felt suggested a good working environment and a stable core staff team.

We spoke with staff who told us the deputy manager had been very supportive in the absence of the home manager. They said, "X (deputy manager) is very approachable. We can go to her anytime with anything and it's never an issue." Staff told us there was regular staff meetings held at the home which gave them the opportunity to give their opinions and feedback on the service. We saw minutes which showed regular, monthly meetings had been held with all staff working at the home which included catering and kitchen staff, night staff, senior care staff and the full staff team. This showed staff were appropriately supported in relation to their caring responsibilities and were regularly updated about any changes in the service.

We looked at a range of audits which the deputy manager told us were carried out on a regular basis. These were in place to allow for the monitoring of the quality of the service provided by the home. We looked at medication audits which had been carried out between November 2014 and March 2015 on a monthly basis. We saw there were issues identified with regard to missing signatures on people's MAR charts. The audits did not indicate if action had been taken in response to this. We spoke with the deputy manager who told us they had addressed this issue through supervision with the senior staff who were responsible. We looked at supervision records but theydid not reflect any discussion of this issue with any of the senior staff members.

The home sent us an action plan following our last inspection regarding the improvements they needed to make in relation to the care plans in place for people. We found the action plan had been implemented and saw a good level of detail had been put in place about people's relationships, communication, health, night time support and interests of the person. Each person's care plan reflected the needs of the individual looking at their likes, dislikes, choices and their preference around personal care. These detailed information aboutthe person and their everyday preferences.

We looked at evidence which showed that audits had been taking place regarding the cleanliness of the home cleaning schedules were completed daily by staff and any issues relating to infection control were addressed with the deputy manager and dealt with in a timely manner. Maintenance of the outside environment was also audited and this included looking at the guttering, fencing and daily visual checks were also in place. The deputy manager had looked at these and we saw evidence which showed they had taken action where issues had been identified and responded appropriately. We found COSHH regulations were in place and also Gas safety certificates were in date and checked. Hygiene services were also monitored by the deputy manager of the home with appropriate bins in place to safely remove any waste items from the home.

The deputy manager and the head of care operations were responsive to our feedback and told us they were committed to improving the service to ensure a person centred approach throughout the home. They said they had already completed an action plan which included a review of all care plans for the people in the home. They also told us they were seeking advice from external agencies to support the delivery of the service by contacting the local pharmacy to complete comprehensive audit of the medication following the concerns we raised.

The manager told us that they were looking into and reviewing their systems to implement a more robust system to review accidents and incidents in the home.

They told us they planned to implement a comprehensive staff training matrix which would identify where training needed to be updated. This would mean that staff would have the required skills to be more effective in their approach particularly around medication and individual medical needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (g)the proper and safe management of medicines; How the regulation was not being met: People were not protected against risks of medicines because the provider did not have appropriate arrangements in place to safely manage them. Regulation 12.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11.- (1) Care and treatment of service users must only be provided with the consent of the relevant person. (3) If the service user is 16 or over and is able to give such consent because they lack the capacity to do so, the registered person must act in accordance with the 2005 Act. How the regulation was not being met: The provider had not done all that was reasonably practical to assess peoples capacity.