

## Joseph Rowntree Housing Trust

# Red Lodge

### Inspection report

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### Ratings

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

# Summary of findings

## Overall summary

This inspection was carried out on 27 September and 4 October 2017. The inspection was unannounced on the first day and we made arrangements to return for the second day.

Red Lodge is owned by the Joseph Rowntree Housing Trust (JRHT). The home is situated in New Earswick to the north of York city centre. Each person living at the home has their own flat and access to a range of communal areas, which include a restaurant, communal lounge and quiet areas. The home has its own car park and benefits from outside garden and seating areas.

Red Lodge provides a care home service without nursing care and incorporates a domiciliary care service, which assists people residing in the on-site sheltered accommodation. The home is registered to provide care and support for up to 42 older people, some of whom may have a learning disability or autistic spectrum disorder. At the time of our inspection there were 30 people receiving a residential care service and seven people living in the sheltered accommodation who received a personal care support service.

The home had a manager in place and the provider had submitted an application to the Care Quality Commission (CQC), in respect of the manager's registration. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in July 2016 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to ensuring the suitability of workers, staff supervisions and risk management. At this inspection we found that improvement had been made in these areas and the provider was no longer in breach of regulation.

There was a robust recruitment procedure in place to ensure that staff employed were suitable to work in a care setting. Records were retained in relation to agency staff used by the provider, including information about the training they had completed.

Staff received an induction, regular supervision and training appropriate to the role in which they were employed. Checks of staff competency were also completed.

Risks in relation to people's needs were assessed and generally appropriately managed, although we found gaps in one person's care file in relation to individual risks. The information was updated during our inspection. Accidents and incidents were recorded and analysed in order to prevent reoccurrence. Checks of the premises and equipment were completed to monitor their safety.

The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff knew how to respond if they had any concerns. People we spoke with told us they felt safe.

There were mixed views about whether there was always sufficient numbers of staff to meet people's needs promptly. The provider was reviewing the deployment of staffing across the home to enable staff to respond to people in a timelier manner. We will continue to review this at forthcoming inspections.

Systems were in place to ensure people received their medicines safely and the provider was taking action to ensure medicines were stored at the correct temperature.

The provider was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in decisions about their care and for those people unable to make decisions about their care, these were made in their best interests using an appropriate process.

People were supported to maintain good health and had access to relevant health professionals when needed. People's nutritional needs were met and information about their dietary requirements was recorded in their care plans.

People and relatives told us that staff were kind and caring. We observed positive and friendly interactions between people and staff. People's privacy and dignity was maintained.

The provider completed an initial assessment of people's needs and there were care plans in place to guide staff on how to support each person. We found some inconsistencies in care plans and some gaps in the recording of monitoring information, such as food and fluid intake charts. The manager had issued guidance and reminders to staff in relation to care plans and monitoring documentation, but the files we viewed showed that further improvement was required to ensure consistency.

At the time of our inspection there was a lack of structured activities taking place at the home and some people told us they felt isolated as they spend most of their time in their rooms. The provider had recruited an activities co-ordinator who was due to commence in post shortly after our inspection.

People knew how to complain if they were unhappy about any aspect of the service. We saw that complaints were recorded and investigated, although some relatives felt issues were not always responded to straightaway. Other people and relatives were more confident that issues would be addressed.

People, staff and most relatives we spoke with told us that they felt the manager was approachable. The manager understood their responsibilities and notifications had been appropriately submitted to CQC. There was a quality assurance system in place and people had opportunity to feedback on the quality of care they received.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Risks in relation to people and the environment were assessed and generally appropriately managed. Accidents and incidents were recorded and evaluated.

Robust recruitment procedures were in place. There were mixed views about staffing levels and the provider was reviewing how staff were deployed in order to ensure people's needs were responded to in a timely manner.

Systems were in place to ensure people received their medicines safely and the provider was taking action so that medicines were consistently stored at the correct temperature.

Staff understood how to report any safeguarding concerns.

### Is the service effective?

Good ●

The service was effective.

Staff received an induction, supervision and appraisal, competency checks and regular training.

The provider was working in line with the Mental Capacity Act 2005. People were supported to make informed decisions wherever possible.

There were mixed views about quality of food at the home. People's nutritional needs and weight were monitored.

### Is the service caring?

Good ●

The service was caring.

People and relatives told us that staff were kind and caring. We saw positive friendly interactions between people and staff.

Staff respected people's privacy and dignity.

Staff responded to people's diverse needs and received training

in equality and diversity.

### Is the service responsive?

The service was not always responsive.

Care plans gave staff information on how to support people, but some lacked detail or contained contradictory information.

Some monitoring records also required improvement to ensure they were consistently completed.

There was a lack of activities available at the home. The provider had plans to address this as they had recruited an activities co-ordinator who was due to start after our inspection.

People and their relatives knew how to complain if they needed to. Complaints were recorded and investigated. Some relatives felt issues were not always responded to in a timely way.

**Requires Improvement** 

### Is the service well-led?

The service was well-led.

There was a manager in place who had submitted their application to register with CQC. Staff received support and attended team meetings.

Quality assurance checks were conducted to monitor the service provided. People who used the service were consulted on their experiences of the home and monthly residents meetings were held.

**Good** 

# Red 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.

This inspection was carried out on 27 September and 4 October 2017 and the first day of the inspection was unannounced. The inspection team consisted of one adult social care inspector, one bank inspector and an expert by experience on the first day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was conducted by one adult social care inspector.

Before our inspection we looked at information we held about the service, which included notifications that had been sent to us. Notifications are when providers send us information about certain changes, events or incidents that occur. We had received some information of concern shortly prior to the inspection and considered this as part of our planning for the inspection. We also requested and received feedback from the local authority's contract monitoring team.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with 11 people who used the service and three relatives who were visiting. We also spoke with five care staff, the manager, the deputy manager and the quality assurance manager. We looked at four people's care records in detail and elements of two further people's care records. We also looked at medication records, five staff recruitment and training files and a selection of records used to monitor the quality of the service. On both days of the inspection we spent time in the communal areas of the home to observe daily routines and staff interacting with people who used the service. After the visits to the home we also received additional feedback from one person who used the service and two relatives.

# Is the service safe?

## Our findings

We asked people who used the service if they felt safe living at Red Lodge. Everybody we spoke to apart from one person told us that they did. People told us they felt safe because they had personal alarms and staff were around to help them if they needed anything. One person told us, "You can hear them [staff] even if you don't see them." The reason given by one person for not feeling safe was, "There are too many staff I don't know." One relative we spoke with confirmed, "[Name] feels safe here. They know a lot of the staff from the local area so they are familiar."

At our last inspection in July 2016 the provider was in breach of Regulation 12 of the Health and Social Care Act Regulations 2014, Safe care and treatment. This was because the provider had not adequately assessed the risks to the health and safety of people who used the service and had not done all that was reasonably practical to mitigate such risks. The provider had also not ensured that the premises or equipment used were safe or used in a safe way. This included a lack of risk assessment in relation to smoking in bedrooms and a lack of responsive action evidenced in relation to concerns identified with use of a bed rail. Actions identified in health and safety annual assessments had not all been completed and there was a lack of analysis of accidents and incidents to identify trends and reduce the risk of re-occurrence.

At this inspection we found the provider had made improvements and was no longer in breach of this regulation.

Risks associated with personal care were generally appropriately managed. We saw care records included risk assessments to manage risks of falling, including the use of equipment such as bed rails to prevent falls from beds. There were also risk assessments in relation to preventing people developing pressure sores and risks associated with nutrition and hydration. These were evaluated monthly. We saw one care file where there were gaps in information about the person's risk of developing urinary tract infections and nutritional risk. The manager printed out the relevant care plan again and added this to the file straightaway. They also added some additional detail and clarification in to the care plan.

We found staff acted appropriately when they found one person's medical condition meant that they were more at risk from falls. A head protector had been obtained by making a referral to the occupational therapist and chair and mattress sensors were in place to alert staff to the person's movements. This had not eliminated all falls but had significantly reduced the risk.

We looked at the recording of accidents and incidents and the deputy manager was able to show us how staff reported accidents and how they had been investigated. The manager had responsibility to oversee the process and they looked for any trends to mitigate further risks to people who used the service. We sampled three completed accident reports and saw they contained sufficient detail to enable staff to identify if further intervention was needed from health professionals such as the falls team or occupational therapist.

There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. There was a fire risk assessment for the service and personal emergency evacuation plans

(PEEPs) to guide staff on what assistance people would require in the event of an evacuation. The fire alarm systems were regularly tested and serviced and staff were able to explain what action they would take in the event of a fire. We saw from minutes of staff meetings that a new procedure for emergency situations had been shared with staff in August 2017.

We looked at maintenance certificates for the premises, which included the electrical wiring certificate, gas safety certificate, lifting equipment servicing and portable appliance checks. These were up to date. Since our last inspection the showerheads in people's flats had been replaced where required, to prevent the spread of waterborne infections. The legionella control risk assessment was due for review in the month of our inspection and we noted that water samples had been taken prior to the second day of our inspection, in order to check for any risk in this area. The checks in place helped to ensure the safety of the premises.

The manager conducted monthly health and safety audits to identify any actions required. A six-monthly health and safety procedural audit was also conducted by the provider. We looked at the most recent review of this, conducted in September 2017, which showed that actions identified had been addressed within timescales. However, we found during our inspection that there had been delays with some property repairs in the home, such as the repair of a door, and the hot water supply to a bath. The bath had taken over three weeks to repair, although there was another bath available in the home so this had not had an impact on people. The manager told us that a staffing restructure in the provider's properties department in 2017 had contributed to communication issues and a delay in these repairs. They advised us the issues were now resolved so any necessary repairs moving forward would be actioned in a timely manner.

We asked the deputy manager about the recruitment of new staff and they told us that recruitment files were kept centrally at the provider's head office. We were shown evidence of a satisfactory Disclosure and Barring Service (DBS) check for four staff members. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. The information also showed us that consideration had been given to obtain references and checks for any gaps in employment history. We were able to discuss the recruitment process with a newer member of staff who confirmed the information that had been requested and obtained prior to them starting work. This showed that the provider had a process in place to check the suitability of staff employed.

At our last inspection we found that the provider did not always carry out and document checks on agency staff to help ensure they were suitably trained and of appropriate character to work with vulnerable people. At this inspection we looked at the agency file and found that evidence was available to show that the provider checked the training and suitability of agency staff.

At our last inspection, people and staff expressed concern about the availability of staffing on a night time. At this inspection, no-one expressed concern about night time staffing. However, there were still some mixed views from people about the availability and response times of staff during the days. Prior to the inspection we had also received a concern that staff were not always prompt to respond to people's request for personal care. We looked at rotas for the last four weeks and found that agency staff were used when required to maintain staffing levels. The manager told us that two regular staff had been on sickness leave in the couple of months prior to the inspection, which had meant they had been required to use more agency staff than usual. The regular staff were due to return to work around the time of our inspection, so the manager anticipated the agency staff usage would reduce. We looked at a sample of call bell response times, which the provider was able to monitor and print off. These showed that staff were generally quick to respond to people's call bells, usually within two or three minutes. However, some of the feedback we received suggested that whilst staff may be quick to respond to the bell initially, if the call was considered



non-urgent staff were not always able to support the person with their needs straightaway. Some people and relatives felt there was a delay in staff returning to assist them. The manager told us they would monitor this. They also advised that they had plans to review how staffing was deployed, and introduce a 'zone' system; staff would be allocated into three groups, covering one area of the home each. It was anticipated that this would enable the provider to ensure that support was provided more equitably, according to people's needs. The sufficiency and deployment of staffing was kept under review by the manager. We will continue to review staffing levels at our next inspection.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs). We looked in detail at the medications for four people and found they were administered in accordance with the procedures of the home. The senior carer responsible for administering medication told us that people had a lockable facility in their own flat and the senior would administer the medication at the persons preferred time in their own accommodation. We found medication was securely stored, including controlled drugs, which the Misuse of Drugs Act 1971 states should be stored with additional security.

The manager and the deputy manager undertook audit checks to make sure medicines were managed safely and according to the policies in place. There was evidence that timely action was taken to address any issues identified for improvement.

There were clear protocols for staff to follow when people were prescribed 'as and when' medicines, known as PRN medicines. Staff used a MAR to confirm they had given people's medicines as prescribed. We found the sample checked had been completed appropriately.

We saw records were kept of the temperature of the fridge where some medications were needed to be stored. This ensured they were stored at the temperature recommended by the manufacturer. However, the rooms where medication was stored did not have a record of the temperature. The deputy manager told us that a recent pharmacist inspection had highlighted this and they were in the process of obtaining a thermometer to monitor the room temperature. We discussed including checks of the temperature checks in people's own rooms, where some people had their medicines stored.

We were told that one person managed their medication independently. We saw a risk assessment had been undertaken to ensure the person understood their responsibilities when managing their own medication. The risk assessment needed to be more detailed and should include the person's views and agreement with the safe management of medicines.

The provider had a policy and procedure in place to guide staff in safeguarding vulnerable adults from abuse. We looked at the provider's records of safeguarding referrals they had made to the local authority in 2017. These evidenced that appropriate action had been taken in response to these concerns. Staff received training in safeguarding and the staff we spoke with were able to describe what action they would take if they had any concerns. This showed there were systems in place to respond to safeguarding concerns and help keep people safe.

# Is the service effective?

## Our findings

At our last inspection the registered provider was in breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because care staff did not receive supervision and appraisal to ensure their competency to undertake the role.

At this inspection we found the provider had made significant progress in this area. Staff files we viewed showed that staff received regular supervision and had opportunity to discuss their training and development needs. Supervision meetings included discussion about achievements and challenges, plus a review of progress against actions set at the previous supervision. The manager and deputy manager maintained an overview sheet with the dates that staff supervisions were completed, so that they could see when supervisions were due. Annual appraisals were also conducted. We spoke with staff about the support they received. They confirmed they had regular opportunities for formal supervision and also attended staff meetings. They said they felt supported by the manager and the deputy manager.

We spoke with one new care staff member about their induction and training. They told us that the induction was comprehensive and thorough. One week was spent at the organisation's headquarters where all of the subjects considered essential to the provider were covered. The staff member told us that they had also attended further face to face training and had completed on-line courses. They confirmed that they were working towards the Care Certificate. The Care Certificate is a nationally recognised set of standards, which should be covered as part of the induction of staff new to working in care. Care staff should adhere to these standards in their daily work.

The provider retained records of the training that staff had completed. These records showed that a comprehensive range of training was provided. This included dementia awareness, communication, first aid, health and safety, moving and handling, fire safety and infection control. Training was refreshed regularly, to ensure that staff's knowledge was kept up to date. Staff responsible for the administration of medication had their competency re-assessed annually, in order to make sure they adhered to good practice.

The provider had an agency staff induction folder. This contained details of each agency staff member's training record and their completed induction checklist for the service.

We asked people who used the service whether they were happy with the care they received and whether they thought staff had the right skills for the job. Most people we spoke with were very happy with the staff and one told us, "Most [staff] are good." Although one person commented, "There are loads of agency staff and they never know what to do, I have to tell them."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received training and understood the requirements of the MCA. Where people had been deprived of their liberty, applications had been submitted to the local authority for a DoLS authorisation. Five applications had been submitted at the time of our inspection, and a record of these applications was retained by the provider.

We looked at six care plans which included assessments of people's needs. We found there was evidence that people were consulted about how they wanted to receive their care. Consent was gained for things related to their care. For example, we saw people had consented to the use of photographs on care plans and medical records. People were also consulted about their continuing involvement in care plan reviews.

We looked at whether people received adequate support with their nutrition and hydration. We saw care plans included nutritional risk assessments and people had appropriate records to ensure staff understood their nutritional needs. Speech and language therapists were involved where people were identified as being at risk from choking. We saw good detail on one of the plans we looked at about the food that the person could and could not eat due to their medical condition.

Records of people's weights were maintained and we saw action had been taken for one person who had lost seven pounds over a period of six weeks. There was clear evidence that medical advice had been sought and fortified drinks and shakes had been obtained and introduced to prevent further weight loss. Staff we spoke with told us they also tried to encourage the person to eat food and snacks that had high calorific value, but said it was difficult as the person had a poor appetite.

There were mixed views about the variety and quality of food available at the home. One person told us, "Lunch was nice today. The pie was nice and the soups are really good. But it's a mixed bag" and others commented that they did not always like the food and felt there were too many chips. One person who was not keen on the food confirmed that staff had tried other foods for them. One person told us, "I am asked for my choice just before the food is delivered." Two other people who received food in their rooms said they used to receive a menu in advance so that they could look forward to their food, but they no longer received a menu. The manager told us the system had changed in order to try and give people more choice and flexibility with their meals, including their breakfast. We were told that people should have a copy of the four-weekly menu in their room, and that staff should discuss with people when they supported them first thing in the morning what they would like for lunch. The feedback from people suggested this was not consistently happening. The manager said they thought this may be because they had been using more agency staff recently, so agreed to issue a reminder to ensure that all staff were consistently offering a choice of meals. A 'food group' meeting had taken place in February 2017 to discuss people's views and ideas for changes to the menu and another meeting of the 'food group' had already been arranged prior to our inspection. This was due to take place shortly after our visit.

We observed food being served in the dining room on two mealtimes during our inspection. People received appropriate support and encouragement to eat their meals. People had a choice of cold drinks with their meal, and hot drinks were offered at other times throughout the day.

The kitchen had an environmental health office food hygiene rating [FHRS] award of 4. Ratings are based on

how hygienic and well-managed food preparation areas are on the premises. A food preparation facility is given FHRs ratings from 0 to 5, 0 being the worst and 5 being the best. An FHRs rating of 3 is acceptable.

People's health care needs were monitored and records in people's care files showed they had been supported to access health care professionals where required. This included GP's, district nurses, occupational therapists and physiotherapists. In one person's file we noted staff had requested a referral to the occupational therapist due to the person having had some falls. People could also access an optician who visited the service if they wished. Contact with healthcare professionals was recorded in a 'Medical Appointment / Advice Record' in people's care file.

People who used the service confirmed they could access their GP and one relative told us, "I think they [staff] do pick up on any changes in [Name]'s care needs or health."

The layout and décor of the home was dated in parts and could be improved to make it more appropriate to the needs of people who used the service. For instance, some corridors were sloped and not easy to navigate. However, the provider had already recognised this and plans were underway to develop new purpose built accommodation behind the site of the existing property by 2019, to replace the current building. Information display boards and plans for the new accommodation were on display to keep people and relatives informed.

# Is the service caring?

## Our findings

People and relatives we spoke with were all positive about the staff and said they were kind and caring. Comments from people included, "The staff talk to me like I'm an ordinary person" and "They care alright, but seem understaffed." Another person said, "It is important to have staff you get to know, and I like getting to know about their family." Two other people we spoke with commented positively on individual staff members they liked and one also said, "They're all nice." One relative told us, "The staff are lovely. And [Name of person who used the service] would tell you themselves that the carers are lovely." Many of the staff had worked at the home for a long time, so people had built good relationships with them.

Staff told us they got to know about people's needs from spending time with them, reading their care plans and discussing changes in handover meetings. Daily records made by staff described how the person had been throughout the day, tasks or activities they had taken part in and how their mood had been. We saw evidence in people's care files that they had been involved in decisions about their care.

We observed staff interacting positively with people who used the service throughout our inspection. Staff were polite and sensitive to people's needs. They spoke to people in an encouraging manner when providing support. For instance, we saw two staff assisting someone to mobilise, and staff explained what was happening throughout and offered reassurance. This enabled the person to be as independent as possible, while providing them with the support and assistance they needed.

We found that staff spoke to people with understanding, warmth and respect, and took into account people's privacy and dignity. For instance, we saw that staff brushed one person's hair to promote their dignity and smarten their presentation before they went to eat, because they knew this was important to them. We also saw staff knocked on people's bedroom doors before entering. This showed staff respected people's privacy. We asked staff about how they respected people's privacy and dignity. They gave us examples including ensuring doors and curtains were closed when providing personal care, covering people whilst washing them, asking people discreetly if they needed assistance with personal care needs and making sure people's clothing was adjusted properly. They also told us about the importance of ensuring people could have private time with their family, visitors or the doctor if they wished, and giving them time to open letters on their own.

The atmosphere in the home was relaxed and friendly, with staff coming and going throughout the communal areas and calling in on people in their rooms to offer assistance, meals and drinks. We observed that some periods of the day people were sat on their own or in small groups with limited stimulation and activity, but staff engaged with people politely as they went past and whenever people requested something.

Two people we spoke with felt isolated in their rooms, where they choose to spend most of their days. One person told us they were concerned that if they became unwell in the communal area, staff may be too busy to help them return to their room as quickly as they would like. They told us this had happened before and it had resulted in them feeling less confident about spending time away from their room. We also found that

although staff called in to see people in their own rooms throughout the day, to take meals and offer assistance with personal care, many of these interactions were task focussed, rather than allowing significant time for conversation or focus on promoting the person's confidence and emotional well-being. We discussed with the manager about the support and interaction for people who spent most of their time in their own rooms, and they told us staff regularly encouraged people to come to the communal areas and join in activities if they were able to. The manager told us they also spent some time chatting with people on a one to one basis in their rooms.

Visitors were welcome at any time and people were supported to maintain relationships with those important to them. We saw relatives visiting their family members during our inspection and they sat together either in communal areas or in their own rooms. One relative confirmed, "I come nearly every day. You can visit whenever you like."

The provider had information available about local advocacy services for anyone who may benefit from an advocate. This was on display on the notice board in the home. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities.

We spoke with staff about how they met the diverse needs of people who used the service, including the protected characteristics of the Equality Act 2010. Staff adapted their support in response to people's individual needs, physical abilities and age related conditions. Some people had religious needs and we were told that one person went to the church of their choice independently. Staff completed training in equality and diversity and the provider had an equality and diversity policy statement.

## Is the service responsive?

### Our findings

The provider conducted an assessment of people's needs prior to using the service, either on a residential care basis or to receive support with personal care in their own accommodation. This enabled the provider to ensure they were able to meet the person's needs. The assessment was used to develop a care plan for each person to guide staff on how to meet people's needs.

Care plans contained person centred information, including an introductory section about what was important to the person, information about their personal history, preferences and the support they needed. There were then specific care and support plans in relation to a variety of areas, such as relationships, daily living, leisure time, personal care, night time support, communication, health, eating and drinking, mobility and end of life care.

Care plans were reviewed monthly, involving the person where they were able to take part. Two relatives told us they were also fully involved in care planning for their family member, but one relative we spoke with did not feel involved in decisions about their family member's care. We saw examples where information was updated or added to care plans, to reflect any changes. However, some monthly review entries were only brief, such as 'No changes required to care plan.' We saw some anomalies in one care plan where the updates lacked detail and were contradictory to other aspects of the care plan. For example, the person's care plan in relation to personal care had been recently been updated to reflect that they now needed more support from staff, but the care plan had not been fully re-written, so still stated that the person was 'very independent' within the same document, which was contradictory. We discussed this with the deputy manager and this had been addressed when we returned for the second day of the inspection. We also discussed adding clearer instructions and detail for staff in the care plan.

One person was receiving support from the district nurse for a sore area to their skin and their care file lacked detail in relation to this. It was not cross referenced in their personal care or health care plans. An entry in the 'Medical Appointment / Advice Record' form had also been incorrectly entered, suggesting the person may need pressure relieving equipment, but the manager advised us this was an error. Whilst the person had received support in relation to addressing the skin issue and we were advised that the problem was now nearly resolved, there was no clear chronology recorded in relation to this.

We saw from staff meeting minutes and a 'care and support plan guidance' document recently issued to staff, that the provider had been working with staff to improve the quality and consistency of care plans. The manager advised us that work on this was on-going.

Staff completed specific monitoring records where these were required, such as food and fluid intake monitoring charts. They also completed daily care and support records, to summarise the care provided and any issues with the person. This enabled the provider to monitor that care delivered was in line with the care plan and responsive to people's needs. We found that the food and fluid monitoring records for two people lacked detail about the amount of food and fluid they had consumed. We saw that this issue had also been identified by the manager and discussed with staff in a recent team meeting. The records we

viewed still lacked detail in some cases, which showed us that further work on this was required to ensure consistency.

We observed the handover between the day shift and staff arriving for the afternoon shift. This was informative and inclusive with staff asking appropriate questions about people's care. We saw that two of the four staff working in the afternoon were agency staff. It was clear that they had worked at the home on several occasions as they knew the people who were being discussed and were able to join in discussions about people's health and wellbeing.

We asked people about the range of activities at the home and the support available to pursue their interests. Several people told us that there used to be a variety of volunteer led activities in the home, such as a 'knit and natter' group, chair exercise and carpet bowls, but these had stopped this year and people said they were much missed. People told us they were not aware why the activities had stopped. During our inspection, we saw a weekly bingo session taking place at the home, for about 45 minutes. Approximately 10 people enjoyed taking part in the bingo. It was apparent though that some other people sitting further away in the communal area did not like the noise of the bingo and one person was visibly agitated by it. This was not noticed by staff and alternate activities were not offered. Some people accessed the services of the home's hairdresser during our inspection. Other than this, we did not observe any other leisure activities taking place in the communal areas during the two days of our inspection and people's comments included, "There's not much going on."

The manager told us that they had recently recruited a dedicated activities co-ordinator, who was due to start work in the month following our inspection. They also said they hoped that the volunteers may be willing to return to the home to supplement the work of the new activities co-ordinator. We discussed the importance of using activity to promote people's cognitive, physical or emotional well-being, especially considering the needs of those who spent most of their time in their room and were at risk of social isolation. The manager recognised this was an area for development and was keen to increase the current one to one and group activities on offer.

We asked people if they knew how to raise a complaint or concern about the service. People confirmed that they did, and their comments included, "Yes, I can just tell them. They sort things." Relatives also told us they would feel comfortable raising concerns, although three relatives we spoke with said they sometimes had to ask about minor issues or concerns more than once. These included issues in relation to the timeliness of repairs and care issues. One told us, "I can raise things and they will sort it out, but it's just that I do have to speak to them about things and remind them." Feedback we received prior to the inspection also indicated that issues raised were not always resolved to people's satisfaction promptly.

The provider had a complaints procedure and there was information available in the entrance to the home about how to raise any complaints or concerns. We looked at records of complaints, concerns and compliments that had been received by the provider and how these had been managed. 14 concerns had been recorded in 2017. The records we viewed showed that these concerns had been investigated and responded to. Five compliments and thank you cards had been received.

People also had opportunity to provide feedback and raise concerns in surveys, 'food group' meetings and individual reviews.



## Is the service well-led?

### Our findings

At our last inspection the provider was in breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because the quality assurance system in place had not been effective in ensuring that all actions identified in audits had been implemented within an appropriate timescale, such as actions needed in relation to fire and water safety.

At this inspection we found that the provider was now meeting regulatory requirements and was no longer in breach of Regulation 17. We found that the manager completed monthly quality audits as part of the registered provider's quality assurance system. These audits covered checks on medication systems, falls and weights monitoring, staff files and support, staffing levels and health and safety. There were also weekly manager 'walkarounds' recorded. These included checking staff handover and monitoring records, reviews of care, topical cream charts and environmental issues. The manager's 'walkaround' checks also included making observations about various aspects of people's experience of the service, such as mealtimes and activities. We saw examples where action had been taken to address issues identified in 'walkarounds' and audits. For example, minor infection control issues, care plan training, the completion of supervisions and training and setting up a supervision tracker. Plans were underway with regard to other areas of improvement required, such as activities and further improvements to care plans and monitoring documentation.

There was a manager in place who had submitted an application to the CQC to be the registered manager for the service. This application was being processed at the time of our inspection. The manager had been in post for approximately six months.

Most people we spoke with knew who the manager was and told us they were approachable. People's comments included, "She comes in to my room to chat" and "She's just like one of us." However, one person said they hadn't met the manager yet.

Most relatives we spoke with told us the home was well led and spoke positively about the manager. They told us, "They let you know about things going on and any concerns" and "Yes I know who the manager is, it's [Name] and I've had some contact with them." However, one relative said, "I don't think the manager is a good communicator." They felt communication across the home and between staff could be improved, such as letting families know when people had appointments planned.

Staff we spoke with told us they felt supported. They were motivated and positive about their work. The feedback we received during the inspection indicated that since having a manager in post, staff were generally more settled and were clearer about the direction and plans for the service. One staff member commented, "It's a lovely place and a nice feel. One of the nicest places I've ever worked." Another told us, "We're going through a significant change and are aware of the new build coming closer. It's a more settled feel since [Name of manager] came in. It has been about getting everyone all on board to go the same way, and that's starting to happen now. The people we are supporting are starting to change, as we are getting people with more complex needs now, so staff are having to adjust to this. It's still early days for [Name of

manager] but she's starting to get staff on board with this." People also commented positively on the deputy manager and told us that the deputy manager and manager attended handover meetings to keep abreast of issues in the home.

There were regular staff meetings and communication memos which gave staff opportunity to find out about issues relating to the service and to receive reminders on practice issues. We looked at minutes of staff meetings and saw that topics discussed included feedback from residents meetings and 'food group' meetings, reminders about record keeping, DoLS authorisation requests submitted, procedures for emergency situations, corporate briefings, feedback from local authority visits and recruitment updates.

In the PIR the manager told us they kept up to date with best practice via their membership of Independent Care Group (ICG) and regular email bulletins from the ICG. They also received updates from the Social Care Institute for Excellence, National Institute for Health and Care Excellence (NICE) and Skills for Care. The manager told us any applicable information from these was cascaded to staff. The manager was aware of which events they needed to submit a notification to CQC about and notifications had been submitted to us appropriately since our last inspection. This meant the provider was meeting the conditions of registration.

People using the service were encouraged to have their say through 'resident meetings'. These gave people the opportunity to discuss any issues or concerns. We saw from minutes of these meetings that people were kept informed about developments at the home, such as the recruitment of a new activities co-ordinator, the introduction of a monthly newsletter, the installation of wi-fi and the longer term plans for the development of the new building. We noted that some requests, such as for new tea and coffee pots, had to be chased up because they were not actioned straightaway.

The registered provider also undertook an annual survey with people in the home. The 2017 survey was underway at the time of our inspection. We were given examples of action that had been taken as a result of feedback from the previous survey in October 2016. This included the re-introduction of keyworkers for each person. This showed the registered provider had taken steps to make sure that people were consulted and their views listened to.