

Croft Carehomes Limited

Croftland Care Home with Nursing

Inspection report

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2015

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



Overall summary

The inspection of Croftland Care Home with Nursing took place on 27 July 2015 and was unannounced. We also visited a second time on 31 July and 3 August 2015, both of these visits were announced. We previously inspected the service on 14 and 20 October 2014 and, at that time; we found the registered provider was not meeting the regulations relating to staffing, requirements relating to workers, supporting staff, consent to care and treatment, management of medicines and assessing and monitoring

the quality of service provided. We asked the registered provider to make improvements. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Croftland Care Home is a nursing home currently providing care for up to a maximum of 55 older people.

Summary of findings

The home has four distinct units providing care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 37 people were being supported in three of the four units within the home.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff we spoke with were aware of the signs of harm or abuse and their responsibility in reporting their concerns. Risk assessments were in place for people, these included skin integrity, nutrition, bed safety rails and falls.

We saw evidence that regular checks were made on the fire detection system and staff had received fire training. Although there was no record to evidence that all staff employed at the home had attended a fire drill. The home was clean, tidy and maintained.

Recruitment procedures were thorough and duty rotas took account of people's dependency needs and staff skill mix.

People were protected against the risks associated with the use and management of medicines. People received their medicines at the times they needed them and in a safe way.

New staff were supported and there was a programme in place to provide training and support for existing staff.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) 2005 and understood how this impacted upon their role. The registered manager had begun to take action to ensure the home was compliant with this legislation. However, further work was still required.

People told us the food was good and we saw people were offered choice. People had access to, and were offered regular drinks throughout the day, although recording of people's dietary intake was not always clear.

People had access to other healthcare professionals and feedback from a visiting healthcare professional was positive.

The home was difficult to navigate due to a lack of directional signage and the layout of the lounges was not conducive to social interaction.

Staff were kind and caring. We observed staff supporting people appropriately and we saw examples of staff respecting people's right to privacy. Staff encouraged people to make lifestyle choices, for example, which clothes to wear or what to eat.

The registered manager had taken steps to encourage families to be involved in their relatives care and support plan.

People's care and support records were stored securely.

On the day of our inspection the only activity we saw people involved in was attending the hairdresser and having their nails painted. People's care and support records were person centred but there was limited information about people's life history and past hobbies. We have made a recommendation about implementing and developing life history work and a person centred activity programme at the home.

Complaints were recorded, including a record of the action taken to resolve the issues raised.

Feedback from relatives and staff was positive about how the home was managed. The registered manager was organised in her approach to her duties and was knowledgeable about the needs of the people who lived at the home.

We saw evidence that a system was in place to monitor and review the safety and quality of the service provided to people. Regular meetings were held where the views and comments of staff and relatives were recorded. Formal feedback from relatives was gained on an annual basis.

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?

The service was not always safe.

People told us they felt safe and staff understood their responsibilities in keeping people safe.

We were unable to evidence that all staff had attended a fire drill. Hot water temperatures were not routinely checked to ensure the water temperature was safe.

Recruitment procedures were thorough.

People's medicines were managed safely.

Requires improvement



Is the service effective?

The service was not always effective.

Staff received supervision and training.

People care and support records did not evidence the process for assessing their capacity and making decisions in their best interests.

People told us the food was good. People received support to eat and drink.

The environment was not stimulating for people who were living with dementia.

Requires improvement



Is the service caring?

The service was caring.

People we spoke with told us staff were kind and caring. We observed interaction between staff and people who lived at the home to be caring.

Staff responded appropriately to people's needs, respected people's dignity and right to privacy.

People were encouraged and supported to make lifestyle choices.

Good



Is the service responsive?

The service was not always responsive.

The home employed an activity organiser. However, on the day of our inspection we did not see people engaged in meaningful activity. Records indicated the provision of person centred activities was irregular.

People's care records provided person centred information about their care and support needs.

There was a complaints system in place.

Requires improvement



Summary of findings

Is the service well-led?

The service was well led.

There was a registered manager in post who was visible to people and staff. They were knowledgeable about the care and support needs of people who lived at the home.

There was a system in place to monitor the quality of the service to ensure people's safety and welfare.

The views and opinions of staff, people who lived at the home and their relatives was gained and acted upon.

Good



Croftland Care Home with Nursing

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 took place on 27 July 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist pharmacy inspector, a specialist advisor with experience in dementia care 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. The expert by experience on this occasion had experience in caring for older people. One inspector visited the service again on 31 July and 3 August 2015.

Prior to the inspection we reviewed all the information we held about the service. We also spoke with the local authority contracting team. Before the inspection, we asked the provider to complete 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.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with five people who were living in the home, two relatives of people who lived at the home and five visitors, including a GP, community matron and a district nurse. We also spoke with the registered manager, the deputy manager, three nurses, five care staff, an activity organiser and a member of the catering and domestic team. We also spent some time looking at seven people's care records and a variety of documents which related to the management of the home.

Is the service safe?

Our findings

People we spoke with told us the home provided a safe environment for people. People said, "I feel safe. There's always someone around", "I do feel safe here." One relative said, "I think they are safe here." Another relative said, "(Person) is safe here. I have a lot of faith in them (staff)."

All the staff we spoke to, with the exception of one staff member, were clear about safeguarding and their role in relation to reporting any incidents or situations which may put people at risk of harm. One staff member said, "If I saw it (a safeguarding concern) now, I would go to the nurse on duty. If they weren't available I would take it to the manager and if not, I would take it higher. I would take it to the CQC and Kirklees." Another member of staff we spoke with was able to verbalise a number of examples of issues which would require reporting as a potential safeguarding matter. The registered manager was aware of their personal responsibilities for keeping people safe and we saw evidence they referred any concerns to the local authority safeguarding team.

We saw from the training matrix that 45 of the 51 staff listed had completed safeguarding training

within the last two years. This meant staff employed by the service were aware of the signs of harm or abuse and their responsibility in reporting their concerns.

A staff member told us 'senior care staff, nurses and management' completed risk assessments for people and these were kept in people's care plans. In each of the care plans we reviewed we saw risk assessments were in place. These assessed a number of topics including skin integrity, nutrition, bed safety rails and falls.

We saw people were weighed frequently however, the MUST tool score and the relevant care plan were not always updated. The 'MUST' tool is a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition. The registered manager showed us a file where each person's weight was logged, and we saw this recorded action taken by staff where people had lost weight. For example, referring to the GP or commencing nutritional supplements. This meant that despite people's care records not accurately recording this information, we were reassured that appropriate action was being taken where weight loss was identified.

We observed one person who received intensive support from staff to maintain their safety. A document in their care plan recorded 'risk of falling - very likely. Prone to falling. Implications if person fell – serious'. When we looked at the falls risk assessment scale they had been scored as '12 - medium risk of falls'. This indicated that either the risk assessment had not been completed correctly or the risk assessment tool may not be appropriate for this person's needs.

Where risks were identified, equipment was provided for people, this included, sensor mats to detect falls, bed safety sides and pressure mattresses to reduce the risk of pressure ulcers. People who required an alternating pressure mattress had a chart in their bedroom which recorded the daily check made by staff to ensure the mattress was set correctly and functioning properly.

Regular checks were made on the fire detection system and there was a personal emergency evacuation plan (PEEP) in place for each person who lived at the home. A PEEP is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. We spoke with one of the nursing staff about the action to be taken in the event of the fire alarm being activated and they were able to verbalise clearly their role. The registered providers training matrix indicated that all staff had received fire training. We also saw fire drills were completed on a regular basis, however, a record was not kept to evidence that all staff employed at the home had attended a fire drill. Participating in regular fire drills helps to ensure staff are confident in their role and the actions required of them in the event of a fire.

We saw a log book which recorded any maintenance matters, we saw the issues reported were repaired in a timely manner. The registered manager had implemented a number of audits to ensure the premises and equipment were safe. This included checks on the passenger lift, wheelchairs and the nurse call system. The record for the nurse call did not clearly evidence that staff had ensured the call system was fully functioning in both the person's bedroom and en-suite. The registered manager told us they would amend the document to address this matter.

A legionella risk assessment had been completed by an external professional and a member of staff was recording a number of checks in line with the recommendations of the contractor. This included monitoring the temperature

Is the service safe?

of some water outlets. We asked if there was a record of water temperatures for all sinks and baths in the home, we were told this information was not currently being completed. When we checked a small random sample of hot water taps in people's bedrooms the water temperature was not excessive however, if hot water used for showering or bathing is above 44 °C, there is increased risk of serious injury or fatality. We brought this to the attention of the registered manager who assured us these checks would be implemented immediately.

As part of our inspection we looked at how accidents and incidents were recorded and analysed. The registered manager told us staff completed a report form for all accidents and incidents which was then sent to the registered manager to be reviewed. We saw a monthly analysis was completed which recorded the details of the accident and any action taken, for example, referral to the falls team or input from the community matron. This showed the home analysed incidents that may result in harm to people living there and made changes to their care and support where necessary.

Our inspection on 14 and 20 October 2014 found the registered provider was not meeting the regulations regarding staffing. On this visit we checked and found that improvements had been made.

We asked people if they felt there were enough staff on duty to meet people's needs. One visitor said, "Sometimes they don't seem to have enough carers." Another visitor said, "Sometimes they seem to be short staffed. The staff are really nice and caring but they seemed to be run off their feet." A relative said, "Sometimes they could do with a few more staff. They don't have a lot of time to talk to residents."

When we asked staff if they felt there were enough staff to meet people needs, feedback was generally positive. One staff member said, "Yes, we have enough staff. We have a floater and since we have had the floater it's been a lot better." Only two staff told us there were not enough staff to meet people's needs, one said "No there is not enough (staff). We need more staff, more staff would make it safer, we don't have enough time to spend with the residents." Another member of staff told us. "We are meeting people's physical needs but we don't have time to sit and talk to them. No time to just sit with them." Throughout the

inspection we observed staff to be busy and people's physical needs were met in a timely manner. However, we did not observe staff sitting down and spending time with people other than as part of a care related task.

The registered manager showed us the dependency tool they used to formulate the staffing for the home. We saw this was completed and reviewed on a frequent basis. We reviewed the duty rota for a two week period and saw evidence the registered manager also aimed to ensure there was an appropriate skill mix on duty for each shift. One of the staff we spoke with said, "When rotas are done, the nurses and deputy manager do it as a mix of skills." This information demonstrated the registered manager took factors such as people's needs into account when considering the duty rota.

Our inspection on 14 and 20 October 2014 found the registered provider was not meeting the regulations regarding requirements relating to workers. On this visit we checked and found that improvements had been made and the registered provider's recruitment procedures were thorough.

We looked at three staff files and saw that procedures had been followed to make sure staff employed at the home were suitable to work with vulnerable people. We saw staff members had completed an application form and a record was retained of notes made during the candidates' interview. Gaps in employment history had been explored, references had been sought and potential employees had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Our inspection on 14 and 20 October 2014 found the registered provider was not meeting the regulations relating to the management of medicines. We issued a warning notice requiring the provider to take swift action to improve the management of medicines within the home. On this visit a specialist pharmacist inspector checked and found that significant improvements had been made and people living at Croftland Care Home were now protected against the risks associated with the administration, handling and recording of medicines.

We looked at the medicines, medication administration records (MARs) and other records for 10 people living in the

Is the service safe?

home. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. Medication records were clear and it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. On occasions where medicines had not been given, staff had clearly recorded the reason why.

We saw that suitably trained staff supported people to take their medicines in ways that maintained their individual needs and preferences as much as possible. The registered manager told us they planned to update the care plans of people prescribed medicines that only needed to be taken 'when required' to include more detailed personalised information. This would enable staff to administer each person's medicines consistently and correctly.

Regular audits were carried out to determine how well the home managed people's medicines. We saw evidence that where concerns or discrepancies had been highlighted, the registered manager had taken appropriate action in order to address those concerns and further improve the way medicines were managed within the home.

During the period of our inspection we found the home to be clean, tidy and odour free. The registered manager told the home had recently been audited by the infection prevention and control team and had scored 93%. The registered manager also said the kitchen had been inspected by the local authority environmental health team and the kitchen received a five star rating. The scale for these ratings goes from '0' - urgent improvement required to '5' - hygiene standards are very good. This five star rating assured us the safety and hygiene standards at the home were very good.

Is the service effective?

Our findings

People who lived at the home told us the food was good. One person said, "The food is quite good. We get a choice. They come round twice a day with meal alternative." Another person said,

"The food is very good and I mean very good. You get a choice for all meals."

We asked two of the nurses how information was passed between shifts. They told us there was a handover at the start and finish of each shift. One of the nurses told us a 'handover sheet' was used and each person who lived at the home was discussed, "What has happened on the day. If someone is in hospital, if they don't come back from hospital and anything else we need to tell about the person." Both nurses' also told us a diary was used to pass on information which may need action by another staff member or to remind staff if someone had a hospital appointment.

All the staff we spoke with told us they had received significant amount of training during the last few months. Staff told us this included a variety of subjects including, moving and handling, infection prevention and control, fire and safeguarding. We looked at the training records for three staff and saw certificates which evidenced various training had been completed. The registered providers training matrix recorded the name, role, start date of each staff member and the date each training course had been completed. The matrix also clearly highlighted where individual staff required refresher training and if a date had been set for this training. This demonstrated staff received an ongoing programme of professional development.

In each of the three personnel records we saw documented evidence the staff member had received an induction to the home. Staff we spoke with told us new staff shadowed experienced staff when they began employment at the home. One staff member told us, "I worked with a senior carer who explained things really well and was very welcoming." Another staff member told us, "I support new staff, I teach them how I was taught, I teach them the right way." This evidenced new employees were supported in their role.

Staff also told us they received regular supervision with either the registered manager or the deputy manager. The three personnel records we reviewed all contained

evidence of a regular programme of supervision. The registered manager showed us a spreadsheet they kept which logged staff supervision. They told us this enabled them to ensure all staff were up to date with their supervision.

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) are part of the Mental Capacity Act (MCA) 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.

Our inspection on 14 and 20 October 2014 found the registered provider was not meeting the regulations relating to consent. On this visit we checked to see if improvements had been made. We found a number of improvements had been made to address the concerns we had previously identified however, some further work still needed to be done.

We saw from the registered providers training matrix, staff had received training in the MCA and DoLS. Staff we spoke with confirmed they had received training, one staff said, "It's to do with how much an individual can make safe decisions. If they can't make a decision, it's about asking them." Another staff member told us the MCA was, "Not depriving the service user of making the decisions themselves." A nurse we spoke with said, "We must assume everyone has capacity, we can't assume they don't." Two of the staff we spoke with were unclear about their understanding of the act and its relevance to the people they supported.

Access within the home was restricted by key coded doors and some people who lived at the home required the use of bed safety rails, sensor mats and regular observation from staff. The registered manager told us there were currently only two people in the home who had a DoLS authorisation in place. We asked them if there were any other people in the home who may require a DoLS application, the registered manager showed us a document which detailed the names of people who they planned to submit an application for and a time frame for submitting them to the local authority. This demonstrated the registered manager had a plan in place to ensure DoLS application were submitted for people whose liberty may be being restricted.

Is the service effective?

We saw people's care plans referred to people's level of capacity and their ability to make decisions relevant to that care plan. Where people lacked capacity the care plans recorded the action staff should take and references were made to staff making decisions in people's best interests. However, we did not see any recorded evidence of a formal assessment of people's capacity in any of the care and support plans we looked at. For example, one person required their medication to be given covertly. This is where the person's medicine is given to them in a disguised form. The records detailed the person lacked capacity, a capacity assessment has been undertaken and a best interest decision had been made by the GP and the pharmacist. The care and support records did not detail the assessment and decision making process.

We saw jugs of juice and glasses were in people's bedrooms and people who were sat in communal areas had access to, or were offered regular drinks throughout the day. We heard staff offering people a choice of both hot and cold drinks, people were also asked if they wanted sugar in hot drinks.

We saw some people eating or being offered breakfast, this included a choice of cereals, porridge, toast or a cooked breakfast.

The menu for the day was written on a white board on each unit with choices available for lunch and tea. However, this was not easy to read on one of the units due to previous 'rubbing out' on the board.

We observed lunchtime on each of the three units. Lunch was taken to each unit in a bain-marie and served by a member of the catering team. Staff offered people a choice of meal and we observed some people being shown both meals to enable them to decide which option they would prefer. One person liked both choices and was given a small portion of both meals on their plate. People were asked if they wanted gravy, however, vegetables and potatoes were plated up by staff which meant people were not able to personalise their selections to their individual tastes.

We saw one person choosing a yoghurt for dessert but they then realised they wanted rice pudding, staff swapped the dessert promptly and without fuss. Where people needed assistance with their lunch we observed staff supported them appropriately. Staff sat down with the person, spoke

with them and assisted them without people being rushed. Staff we spoke with were aware of which people required soft or pureed diets and people who required liquids to be thickened due to the risk of choking.

We saw a member of staff noting down what people had eaten and they told us they updated people food and fluid charts to record how much they had consumed. Another staff member also said, "We see how much they eat and write it in a food chart and how much they drink." We looked at a random selection of food charts for people and found that the records were not always clear as to how much each person had eaten. For example one record detailed the person had eaten a jam sandwich for breakfast but we observed them to eat one half of a quartered sandwich. This meant the records were not an accurate reflection of the food offered to people and the actual amount people consumed.

The deputy manager told us the home had a good relationship with the local GP practice. They said the GP visited the home each Friday for a 'surgery'. They explained this had significantly reduced the need for staff to contact the out of hours GP service at weekends. A visiting healthcare professional said, "Communication with the GP surgery has improved. The organisation of information and the information given (to us) on a Friday for the surgery is all in place."

During our visit we saw a GP and a district nurse visiting the home to see people and we saw documented evidence in people's records that they received input from other healthcare professionals. For example, G.P, district nurse, community matron and optician. A district nurse who was visiting the home said staff referred to them in an appropriate and timely manner. This showed people who lived at the home received additional support when required for meeting their care and treatment needs.

The home was split into 4 distinct units. Only three of which were in operation during the time of our inspection. All three of the units were difficult to navigate due to a lack of directional signage, for example to the dining room or lounges. On Cedar and Ash unit the bathroom and toilet areas had pictorial signage which may not have been easy to see for people who may not be able to remember the layout of the home or had reduced visual ability. The communal toilet had a contrasting toilet seat and hand rails, this helps to draw people's attention to the key features of the room.

Is the service effective?

Redwood unit was dedicated to supporting people who were living with dementia and this unit had bedroom doors painted in various colours. Toilet doors were all painted yellow and doors which were not accessible to people who lived at the home were painted to blend in with the wall colour. Handrails were also painted in contrasting colour to the walls to enable people to see them more clearly.

Ash and Redwood units had a separate lounge and dining room, while Cedar unit had a combined lounge/dining room. There were windows and natural light in each of the areas and while the rooms were practical and functional

they did not appear homely. There was an absence of things for people to engage with such as rummage boxes, sensory or tactile displays, magazines or craft equipment. Chairs in the lounges were arranged around the walls and were not conducive to people engaging with each other. The television was on in each of the lounges, on Redwood and Ash the location of the television meant that some people would have to watch the TV from an angle. Providing an appropriate environment for people living with dementia can greatly enhance people's quality of life.

Is the service caring?

Our findings

All the people, relatives and visitors we spoke with told us staff were kind and caring. One person said, "It's very nice here and the girls are good." Another person said, "The carers are very, very attentive. The staff are wonderful, they are very kind. That's how they are all the time. They weren't just putting on a show for you." A relative commented, "I do like the home. The carers have always looked after (person) well. They've really looked after them." A visitor told us,

"The staff are very caring. The senior carers are very competent. The care that I see is good."

A member of staff said, "I enjoy working here. Going home and knowing I have made a difference to someone's life in a positive way."

We observed staff to be relaxed, friendly and caring, interactions with people were appropriate and professional. We observed a number of occasions where staff transferred people between wheelchairs and easy chairs using the hoist. On each occasion staff spoke with the person, explaining what they were doing and providing reassurance.

Staff responded promptly when people needed support. For example, while we were speaking to a staff member the emergency call alarm sounded, the staff member left the room to respond immediately. At lunchtime we observed a person start coughing, a staff member responded, offering reassurance and tapping them on their back. When the coughing stopped, the staff member placed a cushion behind the person to assist them to sit up straighter.

People who lived at the home were appropriately dressed, people's nails were clean and men were clean shaven. This indicated staff had taken the time to support people with their personal care in a way which would promote their dignity. Clocks in the communal areas and in people's bedrooms were set at the correct time. Having clocks set at the correct time enables people with dementia to rationalise daily routines, for example, meal times.

People were encouraged to make choices. For example, at lunchtime we heard staff asking people which of the two choices of main meal they would like and if they wanted gravy. We also observed staff supporting people to make a choice over which seat to take in the lounge. A member of staff told us how they encouraged people to make choices,

"We offer them a choice, show them what you mean or what you have for them, visual prompts." Another staff member said, "With (person) I showed her a couple of different dresses, (person) chose which one they wanted to wear. You get to know them but you still offer a choice."

We asked staff if they worked on a regular unit within the home. The majority of staff told us they generally worked on one unit. One staff said, "I mainly work on Cedar, but occasionally Redwood." A nurse we spoke with told us about a member of staff who worked predominantly on a particular unit, the nurse told us, "(Staff) takes real pride in their floor." This meant people were supported and cared for by staff who knew them.

Staff we spoke with were knowledgeable about people's individual care and support needs. One staff member told us how they supported a person getting up in the morning, they said, "(Person, they like to be told what time it is, so they can make the decision as to whether to get up. I then support them to the edge of the bed, help her to walk to the bathroom. (Person) always makes me dry the bathroom floor before they get up from the shower. (Person) will make the decision about their hair and getting it brushed. (Person) often refuses to clean their teeth, so I would ask at the beginning, if they refuse, I will ask at the end of washing and if they refuse I will document it and try later." Another staff member clearly described how an individual was supported to change their position while they were nursed in bed. This meant people were supported and cared for by staff who knew them well.

People's care and support records were stored securely. The office door which had medication trolleys stored and the people's records was kept locked shut when not in use. We saw that when care records were taken out of people's bedrooms they were stored in a unit in the dining area to prevent unauthorised access.

Staff were able to tell us how they respected people's privacy. One staff member explained how they used towels to cover people before and after using the shower, they also said "We close the door, close the curtains. When they (people) go to the toilet, we close the door and wait outside. We ask them if they have finished." During the inspection we observed a member of the domestic team leave a person's bedroom and wait outside to allow the

Is the service caring?

person privacy while using the toilet. We also observed one staff member asking a person if they required the toilet, this was done a discreet manner. This demonstrated staff respected people's right to privacy.

Is the service responsive?

Our findings

We asked relatives and visitors to the home what activities were available to engage people during the day. People told us singers visited the home. They also told us the activities organiser took individuals out into the grounds of the home, people had been to the theatre and on boat trips. One person who lived at the home said, "There haven't been any activities since I came here. I do feel that if we had something where we could do things and think about things it would be better. I think you need a bit of stimulation."

A staff member told us, "(Activities organiser) has been off recently. She does 1:1 or groups. We will do things with different residents. One man plays the piano, one man does building blocks. I've done colouring with (name of person). They have regular entertainers like singers." One of the nurses we spoke with said the activity organiser had a good program for people which included painting, baking and ping pong. When we spoke with the activity organiser they were told us about the activities they organised in the home. We asked them about people who were nursed in their bedroom and they told us they aimed to ensure they spent 1:1 time with each person who remained in their room, at least once per week.

On Redwood unit we saw an activities board mounted on the wall near the nurses office although no activities were listed other than the hairdressing price list. We also saw a photographic mural's of people undertaking activities on Redwood and Ash unit. As there was no date, we were not able to evidence if these pictures were of recent events. In the reception area we saw evidence of art projects completed by people at the home, for example, brooches, pictures and a model aquarium.

During the first day of our inspection the hairdresser was attending to people's hair in the hairdressing salon during the morning. The atmosphere in the salon was friendly with chatter and banter between the hairdresser and the people in the salon. In the afternoon we observed the activities co-ordinator painting some of the ladies nails. We did not see people engaged in any other activity.

We looked at the activities record for six people and found the provision of meaningful, person centred activities was limited. For example, one record detailed the person had

four episodes of 1:1 activity totalling less than one and half hours over a period of 17 days. Another person had 9 episodes of activity over a period of 25 days, four of which were listed as 'hairdressing day'.

In each of the care and support records we looked at there was limited information about people's life stories, hobbies and interests. This information can influence how people behave today and enable staff to support people to engage in meaningful activity, in a topic which is of personal interest to them. We recommend the registered manager seek advice and guidance from a reputable source, about implementing and developing life history work and a person centred activity programme at the home.

The registered manager told us the care plans had been put into a new format. Each of the care and support records we reviewed was neatly presented with information easy to locate. The plans were person centred and provided details of the care and support people needed.

Where people may display behaviour which challenged others, care records included potential triggers, and strategies for de-escalating and resolving conflicts. Plans detailed people's abilities, for example, 'can answer yes or no to simple questions, for example 'would you like a drink' and preferences, such as 'likes to wear a nightdress, likes their light out, one pillow and the window closed'. These details helped staff to know what was important to the people they supported.

In one of the plans we reviewed we observed the new documents were not dated and did not record the name of the author of the care plan or the involvement of the person and /or their family. We also noted the nutrition care plan for another person who had lost weight had not been updated to reflect the action staff had taken to address the matter. The registered manager told us staff no longer recorded the monthly care plan review on each care plan, instead, staff recorded the review on a single document. We looked at the evaluation sheet for this person and saw it did not reflect their recent weight loss.

In each of the care and support records we looked at we saw a copy of a letter which had been sent from the registered manager to a family member. This letter informed them of the relatives care plan and invited them to be involved in the reviews and updates. Where this document had been signed by a family member and returned to the home, a copy of this was retained in the

Is the service responsive?

person's care and support plan. We saw one relative had requested they be involved either by telephone or email in the event their relative's care and support plans or risk assessments were amended.

A copy of the registered provider's complaints procedure was clearly displayed on a notice board within the home. A visitor to the home said, "If I have any concerns with

(person) I talk to the nurse." The registered manager kept a record of all concerns and complaints. We saw there were seven complaints recorded for 2015, each entry detailed the date, details of the complaint and the action taken by the registered manager to address the issues. This evidenced there was an effective complaints system in place.

Is the service well-led?

Our findings

Our inspection on 14 and 20 October 2014 found the registered provider was not meeting the regulations relating to assessing and monitoring the quality of service provision. On this visit we checked to see if improvements had been made. We found a number of improvements had been made to address the concerns we had previously identified.

We asked relatives and visitors, their thoughts and opinions about the how the home was run. One relative said, "We go to other places and they are not as good as here." A visitor told us, "From my point of view it compares well with others. It is certainly not the worst home That I've been to."

The registered manager had been employed at the home for over eighteen months. Throughout the period of the inspection they were friendly but professional. They demonstrated knowledge about the care and support needs of the people who lived at the home. Information and documentation we required as part of the inspection process was readily available and the information kept by the service was neatly organised and easily located. The registered manager told us they were proud of their staff team, how they had pulled together and their commitment to completing training.

All the staff we spoke to, with the exception of two staff member, felt the manager was approachable and supportive. A nurse we spoke with said, "Practice wise things are much more how they should be, dressings are being done, we have the paperwork in place, charts for air mattresses, position change charts. Stuff you ask for, you get it. (Registered manager) she works really hard, does a lot of hours, she is very approachable. The staff morale is much happier, they (staff) feel more supported." Another staff member said, "Morale is great here now it's changed for the better, everyone is working as a team, and everybody is nice." Another staff comment was, "Things have improved a lot recently, better team work, we are all pulling together."

We reviewed a number of documents which assessed how the quality of the service provided to people was monitored. We saw evidence the registered provider and/or the area manager visited the home at least monthly. A report of this visit was held by the home and we saw this evidenced what had been reviewed, inspected and

observed and what action was required by the registered manager and/or their staff. Topics included recent safeguarding alerts, action required to meet CQC regulatory requirements and observation of staff practice.

Audits were completed on personnel records, cleaning and maintenance records, daily handover records and medicines. We asked the registered manager if audits were completed of people's care and support records. They told us these were done but they were presently behind schedule with them. We looked at a previous audit which had been completed on person's care and support record, we saw it evidenced any deficiencies and the action that had been taken to remedy these matters. The registered manager also showed us a document they had devised to enable them to ensure staff with delegated responsibilities for completing audits had completed them in a timely manner.

The registered manager also told us that in recent weeks they had received positive feedback from the local authority contracting team, continuing care team, infection prevention and control and environmental health.

The registered manager told us some of the registered providers policies were currently being reviewed by senior management within the organisation and were due to be issued to home in the coming weeks. Reviewing policies enables registered providers to determine if a policy is still effective and relevant or if changes are required to ensure the policy is reflective of current legislation and good practice.

We saw minutes of a daily 'management briefing' meeting which was held between the registered manager, deputy manager and administrator. The registered manager told us this was a quick daily catch up to discuss immediate staffing matters, issues relating to people who lived at the home and to address items listed in the days diary which required action.

Staff told us regular staff meetings were held at the home. One staff told us, "We have three different meeting times in one day, so staff on different shifts can attend." We saw minutes of staff meetings which detailed the date and time of the meetings, names of attendees, which sometimes included the registered provider, and the topics discussed.

Is the service well-led?

The minutes recorded comments and feedback from staff and the management of the home. This evidenced staff were able to express their views and were involved in making decisions about the management of the home.

We looked at minutes of resident and relatives meetings. These had been held in January, April and July 2015. We saw a notice in reception advising people of the date of the next meeting in October 2015. We asked the registered manager how relatives were informed of the minutes of the meetings if they were unable to attend, they told us copies of the meetings were posted out to people to ensure they were aware of the content of the meeting.

A survey had been sent out to relatives in May 2015. The registered manager told us 34 had been sent out and 21 had been returned. We looked at a random sample of the returned surveys and saw that feedback was primarily positive. One relative wrote, "Never really had to complain but general comments have been acted upon." Another relative wrote, "Mum's room is always fresh." We saw the results had been correlated by the registered manager but they told us they had yet to devise and implement an action plan for areas where the home could improve.