Tri-Care Limited

Priestley

Inspection report

Market Street
Birstall
West Yorkshire
WF17 9EN

Tel: 01924474860
Website: www.orchardcarehomes.com

Date of inspection visit:
31 May 2016

Date of publication:
19 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Priestley Care home took place on 31 May 2016 and was unannounced. The home had previously been compliant with all Health and Social Care Regulations. Priestley Care Home is registered to provide accommodation for forty people who require support with personal care. On the day we inspected the home was fully occupied.

The registered manager was present on the day we inspected. 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.

People told us they felt safe and relatives also had confidence in the staff providing care. Staff were able to explain how they would respond to any concerns and what action they would take if they did not feel they were taken seriously enough.

Risk assessments varied in quality and although based on people's own abilities, were not always detailed enough to provide clear guidance to staff, especially in relation to supporting people moving and handling needs. This had been identified by the Operations Manager in a recent visit and work was underway to tackle this area.

Staff were extremely busy all day and very task-focused. They were responsive to people's needs but did not have time to talk to people individually which meant the atmosphere at sometimes felt fraught and hurried. We observed one person not receiving timely continence care which was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were not enough staff to provide prompt and regular support for people.

There were issues with the administration of medication as people were not always witnessed taking it. Records were completed incorrectly as a result as staff wrongly assumed tablets had been taken. Creams and drops were not dated on opening which meant there was a risk medicines were used past their expiry date. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving their medicines in a safe manner.

Staff had access to an induction, supervision and ongoing training although some needed to complete refresher courses in relation to moving and handling practice.

The registered manager had requested Deprivation of Liberty Safeguards (DoLS) for people in the home and was awaiting the outcome of these applications. One urgent DoLS had been authorised and was being correctly adhered to. Staff had a good understanding of mental capacity but records did not always correspond with all aspects of this legislation.

People were supported with their nutritional and hydration needs and pressure care relief was given as required. People had access to external health and social care professionals when needed.

Parts of the home had a strong malodour which had been raised with the registered provider on a number of occasions and the registered manager was awaiting replacement carpets and furniture.

Staff were patient, kind and enabling to people despite being busy. They always acknowledged people and it was clear they knew everyone well. They sought people's consent when carrying out care tasks, however, we could not always see written evidence of this by the necessary parties.

We observed some staff enter people's rooms without knocking first although they did make their presence known. People's dignity was respected for most people apart from one incident where a person needed urgent continence care which could have been provided earlier.

Activities were limited and people did not have a lot to do during the morning apart from attend the hairdresser. Staff were occupied in moving people into wheelchairs for this which took most of their morning as this required two staff.

People's care records were based on their own situation but not all recording was person-centred. The daily records focused on tasks that had been carried out rather than a person's experience of that day.

All feedback we received was positive from people and relatives. Staff felt supported in their role by the registered manager, who in turn was supported by the operations manager. Direction was given to staff and evidence form meeting minutes showed that expected standards were clear and shared.

The quality assurance system was comprehensive and detailed. However, although action points were agreed as completed we did not always see these in practice during our inspection. This meant that sustainability needed further consideration.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff understood how to recognise signs of abuse and knew what action to take and people told us they felt safe.

Although the home had some person-centred records, risk assessments were not detailed enough to reduce the level of risk with safe guidance for staff.

We found staff were continually moving from task to task and this meant people's needs were not always met in a timely manner.

Medicines were not always administered safely and storage of creams and eye drops was not in line with best practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had access to regular supervision and received training although some of this was due to be renewed.

People were not unlawfully restricted as the home had met the requirements of the MCA 2005 by requesting DoLS.

Staff supported people with their nutritional and hydration needs throughout the day and people had access to external health and social care support as required.

Parts of the environment needed upgrading as there was a strong malodour in some sections of the home. This had already been reported to the registered provider.

Is the service caring?

Good

The service was caring.

Staff displayed patience, kindness and encouragement to people.

Although we observed staff seeking people's consent at the time of delivering support, this was not always reflected in written records.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were person-centred and reviewed regularly but not always with the person or their representatives. Some records were task-focused.

We saw that there were limited activities provided during the day

Complaints were handled thoroughly and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, relatives and staff all felt supported and well cared for, and the home had a friendly atmosphere.

The registered manager understood their role and provided clear direction.

Although there was a robust quality assurance system in place, it was not always evident that changes had been made in response to audit findings

Priestley

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 31 May 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in caring for older people.

Before 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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with thirteen people using the service and eight of their relatives. We also spoke with a visiting health professional. We spoke with six staff including one senior carer, three carers, the registered manager and the operations manager.

We looked at four care records including risk assessments, three staff records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

We asked people how quickly staff responded to their needs. One person said "They are not short of staff." Another told us "Staff are always popping in to make sure you're alright." However, another person said "It takes a long time for staff to answer my bell. It depends on what they are doing." A further person said "Staff are very busy." Another person said "I usually have to wait a bit longer at night as it depends on how many people need the bathroom at the same time. It can be up to ten minutes. Usually staff respond to my calls quickly but they've only got one hoist at the moment which is shared." We saw the home had two hoists but one was awaiting repair at the time of our inspection.

While we were speaking with one person living in the home they asked a member of staff for some water. A staff member took away the person's empty glass and in the interim another staff member asked the person if they would like a drink to which the person replied 'cranberry juice.' This was duly promised but fifteen minutes later neither the juice nor water had appeared. We sought the staff member who duly provided a drink and was very apologetic. We were told the drink had been given to a different person which showed the pressure staff were under.

At 9.40am two care staff were in the kitchen area washing cups and preparing the tea trolley in the upstairs lounge. They did respond to call bells in this time but due to their location there was little interaction with people in the lounge. After the tea trolley had been prepared we overheard a discussion about which was the priority task to undertake. The hairdresser was in and some people required transferring into wheelchairs to accommodate this. However, the hoist was in use in someone's room and so people had to wait to be moved.

The lack of an available hoist was an issue throughout the day as we saw staff responding to call bells and then having to wait for the equipment to be free. One staff member advised us the hoist had been out of action 'for a few weeks'. We later spoke with the registered manager who advised us it was since its last inspection on 3 May 2016 where a defective part was found and this was on order. It was due for repair on 3 June 2016.

In the downstairs lounge between 8.55am and 9.50am no staff entered the lounge. Two people were asleep in chairs with their uneaten breakfasts in front of them. One person started calling out as they needed the toilet and they were assisted to their room. The other person then woke up very disorientated and upset and tried to mobilise using the plastic table in front of them. An inspector had to intervene and reassure the person who sat back down but told the inspector they also needed the toilet. They had not been asked by staff who had been in the lounge supporting the other person prior to this. This demonstrated staff were focused on fulfilling key tasks as they arose rather than pre-empting people's needs.

During the offering of morning drinks in the upstairs lounge, which started at 10.20am, the district nurse arrived and so one carer had to respond to them leaving the tea trolley unattended as the senior member of staff was doing the medication round and the other staff member was supporting one person in their room. Staff moved rapidly from one task to another which people responded to by commenting on how busy staff

were.

The registered manager advised us that they used a dependency tool, reviewed monthly, to determine staffing levels and they said staffing could be increased if needed. One staff member said "I enjoy the role but we need more staff to meet people's needs. Personal care support and assisting people with transfers takes all our time as people get older and more frail." Our observations supported this view that we did not feel the current staffing levels were adequate to meet people's needs in a timely manner.

During lunchtime one person was sitting with their skirt very high on their legs and it was evident they needed support with their continence care as they were irritated by their wet clothes. Although staff assisted them into a wheelchair as soon as they realised, this was preventable and reflected how busy staff had been during the morning not to have offered personal care support sooner. The person received the care required and came back to join others in the dining room for their lunch. These observations illustrate a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the home did not have enough staff to meet people's needs effectively and promptly.

We asked staff how shifts were covered. One staff member told us "There are usually three staff upstairs and three staff downstairs, one senior and two carers on each floor. Sickness can be an issue but we rarely have agency staff. We are usually asked if we can help out and staff do."

We checked staff recruitment files and found that all checks had been conducted as required. References for staff had been checked and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Two people told us they felt safe living in the home. We noted one of these people was sat outside the communal area but in view of the lounge by their own choice. They advised us they just shouted and staff attended. One relative we spoke with felt their relation was safe as, "There's always staff around." Staff we spoke with also felt people were safe although were aware that a number of people were living with dementia which posed further complexities to the provision of care. One staff member said "I always make sure I act in a person's best interests and that they are safe. I have never seen any practice here which has concerned me." They knew how to report any such concerns and were aware of the whistleblowing procedure if they felt the matter was not being dealt with effectively. We found evidence that incidents were reported to the relevant bodies as necessary.

We looked at accident and incident records. Records were summarised for each month to enable any patterns to be easily identified and appropriate action to be taken. Where people had had more than one fall actions taken to reduce the risks were recorded. Each specific accident had detailed information regarding the actual event and what immediate action was taken such as seeking medical assistance. Body maps were completed to evidence any injuries and a pain assessment tool was used to identify any concerns of internal injuries. Observations were completed at regular intervals for each person after an accident with evidence of the conversations held with people. This showed the home was taking accidents seriously and ensuring people had appropriate aftercare. All accident records were forwarded to the registered provider who scrutinised them and identified if any further actions needed to take place.

We asked staff how the service managed risks. One staff member explained the fire procedure and the various measures in place to support an evacuation. People's personal emergency evacuation plans contained specific details of how they were to be supported in the event of a fire. In people's care records we found evidence of skin assessments including a Waterlow score (which assesses skin integrity), people's

weights were noted with actions taken if people were losing weight, mobility assessments and falls risk assessments. Each of these had been based on a person's specific circumstances such as their communication ability, balance, pain levels and degree of independence. These factors all helped to shape the care plan in relation to the activity such as having bed rails in place. In one record we noted that it had been agreed by the person they were not safe to have bed rails as they were likely to climb over them, thereby increasing the risk of falls.

However, we also found generic risk assessments in people's files which referenced the use of wheelchairs (even if this was not noted anywhere else in their records), bathing and showering and the use of lifting equipment. Moving and handling assessments did not contain enough details to ensure staff had the necessary information to move someone safely. In one record it was recorded 'use small sling' with no other information about colour or size to aid staff. We observed staff transferring people with the use of the hoist and a stand aid but questioned the appropriateness of this for some people who had specific needs. We spoke with the operations manager who had already identified this area as needing urgent clarity and showed us evidence that the moving and handling trainer was due to re-assess people two days after our inspection visit.

The home used an electronic Medication Administration Record (MAR) system which was backed up by paper records in the event of a power failure. We checked whether stock levels tallied with the records and found they did. Liquid medication was measured correctly and storage room and fridge temperatures were taken. However, we did note that one of the fridges was recorded as between 1 and 3 degrees centigrade which was below requirements. This could affect the efficiency of medicines being kept in it. We also noted not that all creams or eye drops had the date of opening recorded on the packaging to ensure that they were not used after their expiry date.

We found all records of Controlled Drugs were accurate but spoke with the registered manager and the operations manager about the Controlled Drugs storage being on two different floors with medication not being in the corresponding record. This had been identified at a recent compliance visit and was in the process of being resolved. This had meant that some medication had not been returned to the pharmacist in a timely manner.

We observed medication being given to people in the communal lounges. Medication was given to people with an explanation of what it was for. One person was given their tablet by the member of staff who put it in front of them on the table with a fresh glass of water. The person acknowledged the staff member had done this but then the staff member left prior to the person actually taking the tablet. This meant the staff member could not be sure the person had taken the tablet.

During the same round we observed a staff member pointing out to one person they still had their Adcal tablet to chew explaining this was to ensure they had strong bones. We checked the record for this person as the staff member doing medication was no longer in the lounge and found that it had been recorded this person had taken this tablet when they had not. The person did not want to take the tablet and refused it, so this meant their medication record was incorrect. During the afternoon we observed the same thing happen where one person was left with their calcium tablet on the table in front of them but had not taken it. This person did not have capacity and had appeared at various times during the day to be in distress due to their level of confusion. This meant that they needed support to ensuring that they took their medication.
This above examples demonstrate a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not being supported to take their medication safely and checks were not in place to ensure all creams and drops were in date.

Requires Improvement

Is the service effective?

Our findings

One person said "Staff seem well qualified for the job." Another told us "Staff are absolutely brilliant." One relative told us "I feel confident they will look after my relation. I think staff know how to look after them." However, another relative said "Staff are good and they do their best. However, I do not feel staff are trained enough for dementia care."

One staff member told us "I had an induction which included looking at a great big folder! I shadowed more experienced staff while completing all my necessary training and was not allowed to use equipment or do any personal care until this had been completed." We saw staff had access to regular supervision although some of these sessions were generic, information sharing sessions. Each staff file had copies of the meeting which was held with the individual and recent topics had included care plans and reviews and medication. There was also space for personal issues to be noted and an overview of staff's training and development needs to be considered. Records were signed and dated by employee and the registered manager. There was also evidence of shared feedback with staff following a recent visit by the Local Authority Contracts Team showing where issues had been identified and the actions to be taken following the visit. This showed the home was responsive to feedback and keen to ensure best practice.

We looked at training records and found they were thorough. Staff had clear aims and objectives set for each specific training session with expected learning outcomes. Their knowledge was tested after receipt of the training by completion of a question and answer book which was reviewed. Staff had received training in key areas such as diet and nutrition, equality and diversity, fire safety, food hygiene, health and safety, infection control and safeguarding. However, we did note that, in line with comments from staff, only one member of staff had received training in supporting people with dementia and seven out of twenty-five staff had not renewed their moving and positioning practical, six of whom were direct care staff. This had been identified by the registered manager who had contacted staff to ensure this was completed as soon as possible.

People spoke positively of the food. One person said "Meals are very nice" and another told us "I like the menu. I can always have what I like." A further person said "I like to have breakfast in my room." We heard staff asking people their preference for their meal and staff were observed supporting people with their meals if they needed assistance. They were polite and helpful. One staff member told us that one person had 'special utensils' to help them eat independently.

One person took a dislike to the meal that was brought to them so staff brought an alternative. The person disliked this as well so a third option was brought which the person ate. Before the person had finished their first course their dessert was brought but as it was hot the staff member took it away and said 'I'll keep it over here so it doesn't get cold'. This showed the home was receptive to people's wishes and ensured that people had an appropriate diet. Where people had a low weight, their meals were fortified and they were regularly offered high calorie snacks which we saw throughout the home.

One person told us they'd recently visited the dentist with a staff member and another had recently had a

medication review with their GP. People had access to pressure care which was recorded in their daily log. People's skin integrity was regularly assessed and the registered manager informed us no one currently had any pressure sores which showed that the pressure relief was effective.

We spoke with a visiting health care professional who said "It's lovely care here. I would move in here, definitely." They were visiting a person receiving end of life care and said they had no concerns about how this person had been cared for. Care records were detailed reflecting visits by external people and where actions needed to be taken, we saw evidence the home responded in a timely manner.

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

The home had only recently had a locked door due to an incident where someone had left the home who had deteriorated significantly in relation to their ability to assess risks. The registered manager had requested an urgent DoLS for this person and this was in place. One staff member advised us of the recent authorised DoLS in place which was "To prevent the person leaving the building as they would be unsafe as they could not assess risk." The registered manager had applied for a further eight DoLS and were awaiting authorisation from the Supervising Body. This showed the home was aware of their requirements under the Mental Capacity Act 2005 to ensure no one was deprived of their liberty unlawfully.

One staff member we spoke with said "We always assume people are able to make their own decisions. If they are not, then we support them to make choices such as what to wear by offering people different options." They also said any decisions they made had to be in that person's best interests. The registered manager also said "A bad decision is not always evidence of someone's lack of capacity." This showed they understood that people can make unwise decisions under the legislation. They said "We try and encourage people to make safer options and offer the least restrictive choices where possible". We found evidence of specific mental capacity assessments which were endorsed by a best interests decision where it was determined a person lacked capacity. However, not all records corresponded with each other so we discussed this with the registered manager who agreed to check all files and see that this was corrected where appropriate.

There was a strong malodour in the reception area and downstairs lounge which had been noted by the Operations Manager on their recent visit. It had been highlighted this was due to some older chairs which were due for replacement. We found three out of four of the sluice rooms unlocked during part of the day despite there being a large notice saying they were to be locked at all times. People's ironed clothing was also hanging on rails outside their rooms when we first arrived which added to a cluttered feel in the home.

Bathrooms were clean although one had been out of action since August 2015 due to a defective bath lift. People did have access to another bathroom on the same floor. Again, this had been noted by the Operations Manager who was seeking an alternative purpose for the room as people had access to another

bath on the same floor. The communal lounges were lacking in signage and we overheard one person saying to another "What's the day today? We could do with a calendar in here." Another issue we noted with regard to the environment was the moving of trolleys which were used to clear away plates. As they moved from the carpet to the laminate flooring they were very loud and could be a startling noise, especially for people dozing in the armchairs.

Good

Is the service caring?

Our findings

One person said "Staff are helpful. They will always respond to what you need. Both day and night staff are fine." Another said "Staff are very kind" and "Staff are good." A further person said "These are the nicest girls you could meet. They'll do anything for you. If I want something, they say 'sit there, I'll get it for you'."

We observed staff acknowledging people throughout the day. One person asked for a cup of tea at 10am and was advised kindly by the member of staff "Can you just wait two minutes while I help this person?" as they were in the middle of transferring someone from an armchair to a wheelchair. As they were assisting in the transfer of this person the staff members involved were explaining what they were doing and having a conversation with the person who was showing anxiety around their teeth. One staff member gently checked in their mouth and reassured them.

A bit later on one person returned from the hairdressers and asked "Did they clean my neck?" The staff member checked and replied "Yes, it's lovely and clean." Another person requested the toilet and was directed by a staff member with clear instructions on how to locate it, emphasising the sign would be on the door so they knew they had reached the correct room.

We heard one staff member leaving a person's room who was using their commode and saying upon leaving, "If you need me, just buzz. You can reach your buzzer OK, can't you?" They closed this person's door on leaving. This showed that staff were aware of the importance of ensuring people could request help as needed.

When we first arrived in the home we found the care records cupboard wide open with people's care records on full view. The handover log was on the armchair in the ground floor lobby, again compromising the security of information. The cupboard containing the care records was later shut and then finally locked but this meant that people's information was not secure at all times.

We observed staff enter people's rooms slowly although they didn't always knock first. We did hear them speak to people once in the room and pass the time of day. The home had a dignity champion's board on display with key comments around independence, respect, fairness listening and self-esteem. There was also a board citing two members of staff as 'Older Men's champions' although it didn't explain this role.

One staff member told us about the importance of treating people well. They were aware of the importance of good communication such as "how we speak with people and our tone of voice." We observed this staff member on a few occasions and saw this in practice. During the late afternoon we saw one person become quite distressed but they were reassured by staff who spent time with them.

Staff demonstrated a caring attitude throughout our time in the home and were aware of the importance of supporting people near the end of their life. One staff member said "We often just sit and hold people's hands. It's important they know we are there." Care records evidenced detailed end of life care planning showing sections for spiritual care, family, health and social care professionals, people's pain level and

communication needs amongst other areas.

Evidence of people's written consent to care being obtained in their records was poor although we observed staff asking people prior to undertaking any care task. In some care records there was a letter by the registered manager sent to family members asking for any feedback on the care plan or if there were any changes. However, we did not see any written information relating to relatives' responses despite people telling us they had been asked. We were informed by the registered manager that no one currently had an advocate but they knew how to request one if this was needed.

Requires Improvement

Is the service responsive?

Our findings

One person said "I am treated well. Staff will find time to talk to you." Another told us "I go to the local shop to buy sweets for the staff." A further person said "Whatever I need, I just have to call the nurse. They will always turn back."

We asked people in the home if any activities were organised. One person told us "We have [name] who does physical jerks. They get on well with everyone. If it's a nice day we get out for walks." One relative told us they were keen on getting their relation interested in the allotment at the home. The home had a greenhouse and vegetable patch, and was hoping to set up a gardening club.

The upstairs lounge was decorated with union flag bunting following the recent celebrations for the Queen's 90th birthday. During the morning people were listening to music from the CD player and talking to each other. We did not see much evidence of organised activities during the morning and this was commented on by a relative as well. We were also told there were no structured activities at weekends.

One staff member also said that activities weren't arranged as frequently as they could be although people did enjoy music and films. They said they felt limited, "I don't have enough time to do things with people. I would like time to sit and chat with people." This was a view repeated by other staff although one staff member did say "We use the minibus twice a month to go to a local shopping centre and garden centre." During the afternoon the activities co-ordinator came to the home and conducted a quiz for people in the upstairs lounge which seemed to be well received.

In the reception area of the home were displays about winning second prize in a garden competition in the local village and also photographs of the fine dining experience enjoyed by people in the home and local dignitaries the previous summer. There was a poster advertising the forthcoming summer party in July.

We looked at people's care records and found these were audited periodically. We saw that relatives had been sent a letter asking for their opinion of the care plan. However, it was not clear whether they had the authority to contribute to this discussion as there was not always linked to a capacity assessment indicating who had Lasting Power of Attorney or signed consent by the individual to agree to the family's involvement. One relative told us "I was involved in devising a care plan on initial admission" but had had no further input.

Records contained a photograph with key details of the person including their keyworker. Significant medical history was noted as were people's life histories outlining their family, work and main interests. Each support need had a completed assessment which was reviewed monthly to ensure it was still accurate. This assessment formed the care plan which detailed how support was to be provided and was reviewed on a monthly basis. Care plans existed for personal care and reflected people's preferences. In one record we noted 'able to choose own clothes with assistance from staff and likes to wear shoes' and in another the type of shampoo was noted. People's religious preferences were noted and we were told that church services were held in the home regularly.

Physical factors which may have impacted on a person's ability to receive care were recorded such as their dexterity and weight, in addition to mental health factors such as depression or dementia. We found that where needs had altered, changes had been made to the care plan and reviews conducted to ensure issues had been resolved wherever possible. One person required some medical treatment and this was arranged promptly with a successful outcome for that person.

Daily records were mostly task-focused with a record of the key activities undertaken such as washing, dressing and oral care. There was little information about a person's mood or what they had done that day.

In respect of handling of complaints one relative said "I have raised concerns in the past and they were dealt with immediately." We asked the registered manager if there had been any complaints and they told us about one which had already been referred as a safeguarding concern. This was duly responded to appropriately with necessary action being taken. One relative raised their concerns with us regarding the laundry as they felt it had not been addressed satisfactorily despite having raised it with the registered manager. They felt their relation was not always in clean clothes and they often had to change them. They also advised us that they were unaware of the formal complaints policy but would have no hesitation in discussing issues further if they felt it necessary.

There was a display of 'thank you' cards in the ground floor corridor. Comments included 'Very happy with the care provided. Family thought staff were lovely and my relative loved all the food' and 'Couldn't fault the staff. They were lovely, helpful and caring.'

Requires Improvement

Is the service well-led?

Our findings

One person said "We all get on well together." Another said "Nothing can be improved upon" and a further person said "It couldn't be better. Everything is provided here. I can't think of anything that could be done better." Other comments included "I'm very happy here. I've never been more comfortable in my life" and "I couldn't be in a nicer place. I'm happy here." One person who had recently moved into the home said "I get more personal attention here compared with my last home. Standards are good, very good."

One relative said "Everything is spot on. I'm very happy and my relative is very happy." Another relative told us "Everything is excellent – it's purpose built and the care staff are excellent. I can't think of anything to improve it." Staff also spoke positively of the home. One told us "I do enjoy working here. If people living here are happy, then so am I." Another staff member said the home had, "Friendly and welcoming staff and people are happy here." This staff member was keen to tell us "We work in their home" which showed that staff had an appreciation of person-centred care.

We saw minutes of resident and relatives' meeting. These were held every few months and discussed topics such as care plans, staff changes, amendments to the menu based on feedback from people in the home, outings and recent survey feedback. There was also discussion about the 'resident of the day' which involved a deep clean of that person's room, a check on their medication and a care plan audit. None of the staff we spoke with mentioned this during our visit. This meant that this idea was not widely acknowledged within the home.

On the noticeboard in the reception area were the results of a residents' survey. One relative told us their opinion of the care received by their relation had been requested. Only six out of thirty-nine had been returned but an action plan had been created based on issues raised. One of these was the request for a beauty therapist to visit the home. There was also a suggestions box on the wall.

We asked staff if they felt supported in their role. One staff member said "I always feel listened to. The manager will always deal with any issues." Another staff member told us "The manager is very supportive as are the two deputies. I'm confident the manager would deal with concerns appropriately." The registered manager was also keen to say how supported they felt. They were able to ask for guidance on anything and it was always forthcoming. They were aware that things still needed to improve but felt that great progress had been made in providing consistent leadership and guidance. We observed this in written information provided to staff.

Staff meetings were also held at regular intervals. At the meeting in October 2015 it was noted how staff needed to complete their refresher training for moving and handling but we found this was still outstanding on this inspection. Staff were given clear direction by the registered manager as to expectations such as completion of food and fluid charts and to support the activities co-ordinator by encouraging people to attend when sessions were organised. Policy and procedure updates were also discussed and shared with staff, and minutes signed to show attendance. It was not clear how this information was shared with staff who were unable to attend.

We saw that all the equipment had been checked in line with Lifting Operations and Lifting Equipment Regulations (LOLER) at the beginning of the month. This meant that the hoist had been out of action for four weeks putting extra pressure on staff to move the other hoist around the home. Weekly checks were also carried out on wheelchairs and moving and handling equipment. We asked staff what could be improved. One staff member told us "I feel the environment needs upgrading and that we should have baths that automatically switch off as it's too easy to become involved with someone and the bath overrun."

The registered manager explained their quality assurance measures helped them to identify where things needed to improve. They conducted daily checks such as with medication and general walk arounds, dealing with issues as they found them and also looked at other reports of homes rated 'good' by the Care Quality Commission to see what needed to be achieved. Their regular contact with staff helped them keep abreast of key events in the home and the meetings provided a forum for open discussion. We saw evidence of detailed accident logs which had been previously identified by the registered manager as an issue in regards to scant recording and that staff had improved their training completion ratios. The development of the garden area had stemmed from involvement in the 'village in bloom' competition and we saw in the relatives' meeting minutes 'this area is hoped to promote independence and achievement'.

We were shown monthly quality monitoring reports. These were completed by the Operations Manager in detail and were an accurate reflection of their findings. Areas considered included staffing, safeguarding, medication, premises, health and safety, infection control and accidents. Each aspect was analysed and any concerns noted, resulting in an action plan to remedy any deficiencies. However, in the February 2016 report we noted that issues with mental capacity assessments had been identified but these had not all been remedied as we found during our inspection. This meant that although issues had been noted the actions were not always sustained.

The home had a comprehensive monthly audit system looking at people's weights, pressure care records, bed and grab rail reviews, care plans, infection control, medication, incidents and accidents, complaints and equipment such as mattresses and pressure cushions. There was also a six monthly analysis of falls data. The care plan audits were scored upon completion and actions taken where shortfalls occurred.

We asked the registered manager what they felt the values of the home were. They told us "To respect people's dignity. To give people a good life knowing they are happy, content and safe and living in the way that they would like to live." They strongly advocated the use of praise as a motivator for staff and were keen acknowledge when staff had gone above and beyond.

We asked the registered manager to tell us what their key achievements were and they said "To make this home like a big family. People feel comfortable and happy, and know that we will act on any concerns. I want to ensure people are safe. It's a nice place to live."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always being supported to take their medication safely and checks were not in place to ensure all creams and drops were in date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The home did not have enough staff to meet people's needs effectively and promptly.