Eastleigh Care Homes - East Street Limited

Eastleigh Care Homes

Inspection report

90-91 East Street
South Molton
Devon
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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?	**Requires improvement**

Overall summary

Eastleigh Care Home is registered to provide care and support for up to 50 people. The home specialises in the care of older people, but does not provide nursing care . One wing specialises in the care of people living with dementia. There is a manager who is responsible for the home. Currently they have applied to become registered with the Care Quality Commission (CQC) and are going through the registration process. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection carried out on 14 January 2014 we did not identify any concerns with the care provided to people who lived at the home. Prior to this inspection in March 2015 we received some concerns from two sources about lack of staff and whether staff concerns were being listened to. We found that although there were enough

Summary of findings

staff available there were some issues with the way they worked and how they were deployed. Improvements could also be made in providing clearer staff feedback and guidance

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. People were encouraged and supported to maintain their independence. They made choices about their day to day lives which were respected by staff.

Although people said the home was a safe place for them to live, the service was not always safe. The arrangements relating to the provision of meals for people with swallowing difficulties did not minimise risk and there were issues with the deployment of staff in the afternoons and on the dementia unit at night. There was also a risk of infection due to the use of some communal manual handling equipment.

Staff had a good understanding of people's legal rights, however the correct processes had not always been followed regarding the Deprivation of Liberty Safeguards and use of restrictive measures intended to keep people safe.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff spoken with were confident that any allegations made would be fully investigated to ensure people were protected.

People said they would not hesitate in speaking with staff if they had any concerns. People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. One person said "I did have one issue but the manager sorted this out immediately."

People were well cared for and were involved in planning and reviewing their care. However, one person did not have a completed care plan for staff to refer to. There were regular reviews of people's health and staff responded promptly to changes in need. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

Staff had good knowledge of people including their needs and preferences. Staff were well trained, there were good opportunities for on-going training and for obtaining additional qualifications. However, staff said they did not receive formal one to one supervision sessions on a regular basis. Subsequent to the inspection the provider has provided evidence to show staff did have dates booked for supervisions.

People's privacy was respected. Staff ensured people kept in touch with family and friends. Visitors said they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private. People were provided with a variety of activities and trips. People could choose to take part if they wished.

There was a management structure in the home which provided clear lines of responsibility and accountability. The manager showed enthusiasm in wanting to provide the best level of care possible although communication with staff could be improved. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people.

There were some effective quality assurance processes in place to monitor care and plan on-going improvements. There were systems in place to share information and seek people's views about the running of the home. People's views were acted upon where possible and practical. Since this inspection, the provider has sent us a detailed action plan showing what they have done to improve care and support. This includes addressing the areas of improvement we have highlighted such as the purchase of additional hoists and slings, deployment of staff to cover all areas of the home throughout the day and night and better systems to ensure care plans reflect people's needs and where best interest decisions are needed, setting out how this decision has been made to fully protect people's rights.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. The provider had systems to make sure people were protected from abuse and avoidable harm. However, arrangements relating to the provision of meals for people with swallowing difficulties did not minimise risk. There was also a risk of infection due to the use of some communal manual handling equipment.

Although there were enough staff on each shift to meet people's needs there were issues with how the staff were working. The deployment of staff did not ensure people's needs were being consistently met.

Staff were aware of how to recognise and report signs of abuse. They were confident that action would be taken to make sure people were safe if they reported any concerns.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Requires improvement

The service was not always effective. The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards but this was not always clearly documented in respect of the use of restrictive measures intended to keep people safe.

People were mostly involved in their care and were cared for in accordance with their preferences and choices (other than the above) and staff communicated well with people and their advocates.

Staff had knowledge of each person and how to meet their needs. Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect whilst encouraging independence.

People were consulted, listened to and their views were acted upon on a day to day basis. People had access to advocacy services if they needed them.

Where people had specific wishes about the care they would like to receive at the end of their lives these were recorded in the care records with involvement from family as appropriate. This ensured that all staff knew how the person wanted to be cared for at the end of their life.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive. People were involved in planning and reviewing their care. However, one person did not have a care plan at all. The arrangements for sharing information about how to meet their needs with the staff team was not robust.

People received personalised care and support which was responsive to their changing needs and involving appropriate health professionals.

People made choices about all aspects of their day to day lives. People took part in social activities, trips out of the home and were supported to follow their personal interests.

People shared their views on the care they received and on the home more generally with appropriate involvement with people's representatives. People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Requires improvement

The service was not always well led. There was an open culture promoted within the staff team but formal communication and feedback to staff could be improved by the management team.

There were some effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed and the service took account of good practice guidelines. However, some systems to monitor quality had not identified shortfalls in care planning, equipment and reviewing people's social and emotional needs.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Eastleigh Care Homes

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 checked 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 9 March 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by two inspectors due to the size of the service and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the home.

At the time of this inspection there were 48 people living at the home. During the day we spoke with 21 people who lived at the home and seven relatives who were visiting. We also spoke with 12 members of staff, the registered manager and the clinical director. We looked at a sample of records relating to the running of the home and to six care files relating to the care of individuals.

As some people at the service were living with dementia and unable to communicate their experience of living at the home in detail, we used the Short Observational Framework for Inspection (SOFI) in two areas. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. Arrangements relating to the provision of meals for people with swallowing difficulties did not consistently minimise risk. There were no records in the kitchen to ensure kitchen staff knew exactly what type of meal people needed. This was particularly important for people who were at risk of choking and required fork mashable or pureed meals. Meals were sent from the kitchen in trolleys for staff to dish up to individuals in the dining rooms. For example, the cook knew there were three people needing pureed food in the dementia unit and provided one dish with enough puree for three people. Once in the dementia unit there was no information to ensure the correct people received the specialist diet. One care plan for a person who needed a fortified diet stated "care and kitchen staff need to be in communication so they can work together to try and maintain a good diet". We could not see if this person had a fortified diet or not. When we asked the cook and care staff in the kitchen during lunch they said the only means of communicating the correct diet at the time of the meal was verbal. Staff told us "We just know." This could put vulnerable people at risk of receiving an incorrect consistency of food. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff encouraged and supported people to maintain their independence. There were risk assessments in place which identified mobility risks, for example, and the control measures in place to minimise risk. However, the design and layout of the building was such that hoists were required on three separate floors and it was therefore difficult for staff to access the hoists in a timely way. The service had at least nine people who required specialist equipment such as hoists to safely move them. There were two hoists available for use, one was an electronic one and the other a manual hoist which some staff reported was difficult to use for people who were larger. For example, following lunch, three people waited up to 45 minutes to be transferred from their transit wheelchairs to a more comfortable armchair. One person's care plan stated that the person required two staff to assist with mobility unless they were not weight bearing. This person's daily record said on one occasion two staff had been unable to assist the person as they were non-weight bearing so care staff had asked a third care worker for assistance. The records did not state whether the hoist had been used as indicated in the care plan for such times.

There was also a risk of infection due to the use of some communal manual handling equipment. Staff said there were four slings in use for up to nine people. This meant there was not a separate sling for each person own use which is good practice. This presented a risk of cross infection to people. One sling looked frayed and was in need of replacement. We fed this back to the manager and provider representative. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received some information of concern about staffing levels not being sufficient for the number and needs of people living at the service. Staffing levels varied to between eight to ten care staff on the morning shift and seven care staff during the evenings. The issue was identified by staff to be not about staffing numbers but about some senior care staff not assisting with care on the afternoon shifts. The manager was aware of this issue and had discussed this at staff meetings, that the two senior care staff on each afternoon shift did need to take on some of the care tasks rather than spend this time doing paperwork, for example. This had not made this clear in writing with a task list or explanation of the senior carer role in the afternoons for example. Therefore some staff had not felt listened to or seen improvements in how they were supported providing care in the afternoons. People told us "We are never left without for long" and "The staff cope alright with everyone." However, another person who needed assistance to move said "You've got to wait a long time to get to the toilet, the worst time is tea time." One relative said "We are very aware when staff are short. The bell rings forever." We did not hear call bells ringing for long periods during this inspection. Overall, care staff were well supported by a hotel services and laundry team, a cook and two kitchen assistants and a receptionist.

There were always two care staff allocated in the dementia unit. However, at night when four waking night staff were available, they based themselves in the main building unless they were responding to call bells, pressure mats or doing rounds. Care records for people in the dementia unit

Requires improvement

Is the service safe?

indicated that some people could be restless or require assurance at night and some people would not be able to use a call bell. Therefore, staff could not be sure that people living in the dementia unit did not require assistance when they were not present which could put people at risk. The manager said she would look at ensuring there was a more active presence throughout the night in the dementia unit and the operations manager would conduct a thorough analysis to ensure the safe management of the dementia unit at night. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Emergency plans and procedures were in place. These included personal emergency evacuation plans and what staff should do in an emergency. One person said "If there is a emergency they are on the spot to sort it." Accidents and incidents were recorded showing details of the incident and what action had been taken to minimise future risk.

Staff recruitment was robust. The service ensured that new staff had full checks and references in place prior to commencing employment. This including gaining references from their last place of employment and reviewing any gaps in employment history.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. Staff confirmed they had received training in protecting vulnerable adults and knew who they should report any concerns to. Staff were aware there was a policy and procedure they could refer to and were confident any safeguarding concerns they raised would be appropriately dealt with. People told us they felt safe living at the home and with the staff who supported them. People's comments included "Staff know how to help me with a shower safely", "I feel safe", "The staff are all very good to everyone" and ""I feel safe and sound." One person said "It's very good care, they care for you and look after you. I like it here."

Each relative spoken with said they felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any; they felt they would be listened to and action would be taken to address any issues raised. One relative said "I come in every day, as long as the staff smile I can't fault it."

People were supported with their medicines in a safe way by staff who had appropriate training. People were able to manage their own medicines following a risk assessment if they wished. Currently, no-one had chosen to manage their own medication but there were processes in place should people wish to do so. We saw medication administration records and noted that medicines entering the home from the home's dispensing pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record.

A medicine fridge was available for medicines which needed to be stored at a low temperature. Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. We saw that these were stored and records kept in line with relevant legislation. The stock levels of these medicines were checked by two staff members at least twice each day. Checks showed stock levels tallied with the records completed by staff.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Staff had a good understanding of people's legal rights. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. However, the correct processes had not always been followed regarding the Deprivation of Liberty Safeguards (DoLS) relating to use of restrictive measures intended to keep people safe. For example, risk assessments relating to the use of pressure mats to alert staff when people moved and the use of bed rails did not include best interest decision making processes to ensure they were being used appropriately in the person's best interests. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. For example, appropriate applications had been made to the local DoLS team for assessment about specific restrictive decision making such as preventing a person from leaving the home to maintain their safety. Staff practice and records showed also that staff were gaining consent before carrying out tasks and individual care plans showed how to respond appropriately to behaviour which could be challenging for staff relating to people living with dementia.

Staff were able to describe people's needs and wishes in detail and the staff handover between shifts showed staff had detailed knowledge of people's changing needs. Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care. There was a training matrix to make sure staff training was kept up to date. For example, where three staff had not attended training the manager was dealing with this using the disciplinary process. This showed that training was seen as important. One person said "Staff know what they are doing" and another added "Staff are good at showering me and in the bathroom. They know what they are doing". However, one staff member told us their induction had not been fully completed or recorded. The manager and operations manager gave assurances the induction process followed national guidance on key areas to be covered and staff completed a number of shadow shifts with more experienced staff before they were expected to be part of the rota.

Staff gave a variable account of whether they had received one to one supervision sessions and records were not always available to support this. The manager said staff had all been offered one to one meetings and some group support meetings and she would ensure this was documented as supervision. Some staff said if they had raised issues they were not always clear what had been done about it which made them feel not listened to, for example, relating to staffing roles in the afternoons.

One relative commented they felt staff should have training on working with people who are blind or have sight impairment as staff were not always working in a way which showed they were aware of these people's needs. The example was given, of a staff member asking their relative to blow, having been presented with a cake with candles, but the staff member did not describe what they were doing so the person had no reference as to why they were being asked to blow. Another person said they would like to try audio books. The provider said there were audio books available for people to use. However, staff were explaining to people with limited sight at lunch what was on their plates.

People saw health and social care professionals when they needed to such as GPs, dentists, district nurses and speech and language therapists. One person said "Yes, they arrange the dentist, doctor, chiropodist, whatever you need." This made sure people received appropriate and effective care and treatment. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. For example, one person had a small pressure area which was being monitored and staff had involved the community nurses for advice about how best to prevent skin breakdown. People spoke highly of the staff who worked in the home. One person said "The staff are very nice and trained very well."

Requires improvement

Is the service effective?

There were risk assessments in people's care records relating to skin care and mobility. We saw that where someone was assessed as being at high risk, appropriate control measures, such as specialist equipment, had been put in place. Where people had been assessed as being at high risk of pressure damage to their skin, they had the identified pressure relieving equipment and they were being seen regularly by the local district nursing and tissue viability team. This meant people's health needs were assessed and met by staff and other health professionals where appropriate.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. One person at the home had lost a significant amount of weight. Staff told us, and the person's care records showed, that appropriate professionals had been contacted to make sure the person received effective treatment. We read that this person's weight had stabilised and they had now begun to regain some weight which showed that the care was effective.

People were happy with the food and drinks provided in the home. One person said "We get good food and a glass of water. We are always asked what we'd like. Staff just put out what we need. There is a choice of meals and a sweet and fruit. In the afternoon we get a glass of fruit juice and fruit." Other comments from people included "It's all the food I want", "Lovely", "Nice", "Food on the whole is good, you can choose" and "Food is excellent. "

We observed the lunchtime meal being served in the three dining rooms. People sat at tables which were nicely laid and each had condiments for people to use. People were offered a choice of meals. Meals were dished up individually from the food trolley so staff could tailor people's plates for their needs. During the meal staff tried to engage people in discussion and assistance was provided for people who required support to eat their meal. People were offered choices including if they would like gravy, for example. Staff monitored people for their responses to the food where people were unable to voice an opinion due to living with dementia and second helpings were offered.

Throughout lunch people were treated with respect and dignity. They were not rushed. There was friendly banter between people and we saw staff being encouraging in a gentle way. This helped to make lunchtime a pleasant, sociable event.

The home was well maintained and provided a pleasant and homely environment for people. There was adequate space for people to move around as they wished and the décor was appropriate for people living with dementia to enable them to interpret their environment more easily.

Other than enough hoists, people had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home and people had individual walking aids, wheelchairs or adapted seating to support their mobility. For example, one person preferred to sleep in a chair and the home had discussed options with the person and an occupational therapist to see which chair would suit. Another person now had a new electric wheelchair.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff had good knowledge of each person and spoke about people in a compassionate, caring way. People said "The girls are nice and polite. I can't fault it", "Staff are very nice, very good indeed", "We are looked after in every way" and "The carers are fine, most everybody is. They try their best to help you."

Several people also mentioned one of the activities co-ordinators as having a "brilliant rapport" with people and a "very caring approach". One relative commented about a member of the hotel services team who "Went above and beyond their call of duty. My relative loves them." Other relatives commented on how clean the home was and how well laundry was cared for. People were dressed in clean, appropriate clothing and looked well cared for. People had opportunity to have their hair done regularly. One relative said "I take my mum out and when she is ready she says 'I'd like to go home now'. That shows how well cared for she is and that she sees Eastleigh as home."

Staff also supported people in a caring way, explaining what they were about to do, for example help them to move using a hoist. Interactions between staff and people were friendly and warm with humour being used to encourage people in their activities of daily life. Time was spent with one person to reduce their anxiety when moving. Other staff came to chat to take the person's mind off their anxiety and the person reacted in a positive way.

Throughout the day we saw staff interacting with people who lived at the home in a caring and professional way. One staff member said "People are happy here." People chatted happily between themselves and with staff. One person who lived at the home said "I've been here a few months. I was not unhappy to come. It's very nice very good indeed."

People told us they were able to make choices about their day to day lives. They chose what time they got up, when they went to bed and how they spent their day. One person was having a lie in and had asked staff to keep the door open so they could see people and staff respected their choice. They regularly checked that the person was ok. Throughout the day staff were heard to ask people if there was anything they needed or discreetly check if people needed the bathroom.

Relatives confirmed they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room. There were various areas around the home which people could access and spend time and a pretty, well kept garden. Staff acknowledged people and visitors as they went about the home. The receptionist welcomed people as they came and went in the foyer.

People's privacy was respected. All rooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. We saw that bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care.

People said they were involved in care plan review meetings. Relatives were also involved in care planning as appropriate. One relative said "Yes I have been asked all about the care plan and I can go home and know my mum is ok." Another relative said "We have seen great change and improvement in their health due to the care planning, we have good review meetings too."

Care records contained detailed information about the way people would like to be cared for at the end of their lives. There was information which showed the provider had discussed with people if they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions. One relative said ''There is something excellent here I think, which is that they plan with you and your relative for end of life care. I found this to be really good as I feel confident my relative's wishes about end of life care will be carried out. She wants to stay here and not go to hospital and that will happen.'' Arrangements had also been made to meet people's spiritual needs such as organising church denomination visits and ensuring people who could had access to the local community.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive. People were involved in planning and reviewing their care. However, there were no care plans or risk assessments in place for one person who had moved into the home two weeks previously. The arrangements for sharing information about how to meet their needs with the staff team was not robust. When we raised the issue on the day of the inspection an interim care plan with key risks was put in place by the service and the manager assured us priority would be given to completing the care plan. Staff were able to explain the person's general needs but did not know all the details such as dental care, for example.

Staff sometimes did not recognise when people had been sitting in transit wheelchairs for long periods rather than an easy chair. Also in one dining room on the dementia unit, people were taken to lunch too early and had to wait half an hour for lunch to be served. Some people lost interest and wandered out. We fed this back to the manager who said she would look at these issues and feedback to staff.

People were involved in discussing their needs and wishes; people's relatives also contributed. One relative said "We talked about the care plan and I shared some life history information which staff used to plan her care." People received personalised care and support which was responsive to their changing needs. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes.

All other care files we looked at were personal to the individual which meant staff had details about each person's specific needs and how they liked to be supported. They gave staff an overview of people's preferred routines in order to assist them to provide people with care which was person centred. Summaries of care were discreetly kept in people's rooms for staff to refer to as well as a comprehensive staff handover. Food and fluid charts were well maintained and staff totalled input and output and analysed the information. Staff then recorded when people required additional encouragement with fluids for example. However, these charts did not contain accurate information as supplement drinks were given out on medication rounds and not added to the food and fluid chart totals. The manager said they would include this.

Staff at the home responded to people's changing needs other than the above. People said "Everything is OK. I get lots of attention", "Staff know who we are" and "Absolutely marvellous, perfect. Lovely being here." Care plans showed how staff had regularly observed progress, for example one person had new medication and the care plan detailed appropriate actions such as noting behaviour, monitoring reactions and discussing progress with the GP. This person was now having no further falls and medication was given depending on need. Staff had noticed for another person they had painful legs and a visit from the GP had resolved this with appropriate medication.

Discussions with relevant health professionals about behaviour which could be challenging for staff was well reported showing actions taken following advice. Hospital appointments were followed up, for example, where a relative missed taking one person an appointment the manager rang them to ensure they made another appointment. One person was at risk of self neglect and their care plan showed various methods the staff were trying to encourage the person. For example, offering activities they liked, developing a named key worker relationship and communicating effectively with family members about expectations.

People benefitted from an activities co-ordinator and assistant five days a week with care staff assisting at the weekends. There was a lovely atmosphere which relatives commented on, with people chatting and doing things around the home. People were able to choose activities they liked and were engaged doing things or chatting with staff. There was a wide range of activities available morning and afternoon set out in a regular newsletter. For example, exercises, external entertainers, crafts, card games, pet therapy and one to one sessions with people. People were also able to access the community going on trips to the local market and for drives out. Some people had been out to see the snowdrops and a memory café was being held with reminiscence boxes to aid discussion for people living with dementia and their families. People also were able to go out for walks individually with staff at times.

People said "There is enough entertainment", "The physio man comes once a week to give us exercises", "There's

Requires improvement

Is the service responsive?

singing, quizzes, organ, male voice choir, local slide shows etc" and "Most days there is something on; singing, handicrafts, car ride." One relative was waiting for his mother to finish playing cards and was pleased to see her happily joining in. They said "I'm very impressed." Information from care planning had been used to identify person centred activities such as helping someone to knit again and to promote conversations. The manager documented who had attended which activity rather than individually so it was difficult to ensure people were not at risk of isolation or receiving less stimulation. There were records of activities and interactions that had happened in people's individual care plan daily records. However, these had not been looked at as a whole to monitor whether people were having their social and emotional needs met consistently. The manager said they would look at how to monitor how people's social needs were being met in a more individualised way.

People said they would feel confident to make their concerns known and expect they would be resolved. One relative said they had been to see the manager about a few small issues and these had been resolved quickly. Another relative had spoken to the manager about seating arrangements and their relative's interactions and relationships. This had been sorted immediately and reduced the risk of triggering behaviour which could be challenging for staff and distressing for the person. Complaints were well recorded including actions taken and whether the person was happy with the outcome. Any learning was communicated to staff.

Requires improvement

Is the service well-led?

Our findings

The service was not always well led. There were some effective quality assurance systems in place to make sure any areas for improvement were identified and addressed and the service took account of good practice guidelines. For example, quality assurance surveys to monitor people's experiences and enable feedback, good medication and accident audits and comprehensive maintenance of premises and equipment. However, some issues had not been identified. Such as ensuring the appropriate use of some equipment to minimise risk, minimising the risk of choking, ensuring people were responded to promptly and safely and ensuring each person had a comprehensive care plan. Since this inspection the provider has sent us a comprehensive action plan showing they have taken action to address all areas identified within a short time period. New hoists and slings have been purchased. Staff at night have been deployed to caver all areas of the building and audits of care plans have included updating any areas of need for a best interest meeting and decision to be considered.

Some staff had not received consistent and well recorded one to one supervision sessions. These are individual sessions which allow staff to discuss any training needs, competency and concerns. There were issues with the afternoon senior staff roles and some staff felt they had discussed this issue with the manager but had not seen any progress. Communication could be improved and made more regular. Staff meetings were six monthly. However, issues were able to be raised at any time and at staff meetings. For example, a "care staff floater" role during morning shifts had been introduced as a result of staff comments showing that management were receptive to staff concerns and ideas for improvement. Also staff were able to develop their role in care of people with diabetes so they would not need to call the district nurse each time, ensuring less waiting for people. One staff member told us how incredibly supported the management had been of their personal situation.

There were clear lines of accountability and responsibility within the management team and good support from head office. The provider's operations manager helped to monitor the quality of the service by carrying out auditing visits. Managers meetings were held regularly which were recorded and any issues were discussed in detail. For example, pressure area risk, falls risks, behaviour issues and mobility needs were discussed to ensure the relevant health care professionals had been involved. Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs such as health professionals.

The manager, senior care workers and operations manager were available throughout the inspection. They all took an active role in the running of the home and had a good knowledge of the people who used the service and the staff. People appeared very comfortable and relaxed with the management team. We saw members of the management team chatting and laughing with people who lived at the home and making themselves available to personal and professional visitors. Staff said there was always a more senior person available for advice and support. The manager worked occasional care shifts. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. The manager had recently completed some night shifts to do spot checks on care at night which showed a desire to monitor and provide good care.

Care plan audits had been carried out and any shortfalls had been addressed with staff. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

People and relatives described the management of the home as open and approachable. The manager showed a great enthusiasm in wanting to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they interacted with and cared for people. Staff comments included "I enjoy working here. Training is available, a very good care home. Really good team work. If we get short due to sickness extra cover is willingly given", "It's a team where there is nobody who doesn't want to work with anybody", "The style of the home is lovely, we try to be there for the individual" and "The owner is very loyal to the organisation." One care worker said "I have a really lovely job, I recommended this home to my grandmother. It has a good ethos, making sure everyone is treated well and fairly."

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: Records did not ensure people would receive the correct food and fluids to keep them safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were not always enough staff deployed in a safe way to ensure people's needs could be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: There were not enough mobility aids and slings for people to receive assistance in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: There were no records of best interest decision making processes in relation to the use of some restrictive actions.