Orchard Care Homes.Com Limited

Thornton Hall and Lodge

Inspection report

16 - 18 Tanhouse Road
Thornton
Crosby
Merseyside
L23 1UB

Tel: 01519242940
Website: www.orchardcarehomes.com

Date of inspection visit:
16 December 2015
17 December 2015
12 February 2016

Date of publication:
24 March 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection of Thornton Hall and Lodge took place on 16 &17 December 2015 and 12 February 2016.

Thornton Hall and Lodge is registered to provide care and support for up to 96 people. The home is purpose built and the accommodation is over two floors. The home has aids and equipment to help people who are less mobile. The first floor is accessible by a passenger lift and staircase. During the days of inspection, 87 people were living in the home.

A registered manager was in post. 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 living in the home and their relatives, told us Thornton Hall and Lodge was a safe place to live. We found that although some safeguarding referrals had been made, there was no effective process in place to ensure all safeguarding referrals were made to maintain people's safety. Staff had received training in relation to safeguarding.

Medicines were not always managed effectively to ensure people received their medicines as prescribed. Covert medicines were not administered in line with current legislation.

People living in the home and relatives we spoke with, told us there were adequate numbers of staff on duty to meet people's needs. We observed people receiving support in a timely way during the inspection. There was an effective process in place to assist the manager in making safe recruitment decisions.

Risk assessments had been completed to assess and monitor people's health and safety, as well as the environment. People had risk assessments completed in areas such as falls, nutrition and evacuation in the event of an emergency.

Safety checks of the building and equipment had been undertaken to ensure the home remained in a good state of cleanliness and repair.

Accidents were recorded, though actions taken were not always clear. A new process had been implemented to ensure staff acted appropriately in the event of an accident.

Not all staff had a clear understanding of which people had a Deprivation of Liberty Safeguards (DoLS) authorisation in place. Appropriate DoLS referrals had not been made for all relevant people. This meant that people may be having their liberty restricted unlawfully.

We observed staff seeking people's consent before providing them with support. Care files showed that when able, people consented to their care and treatment plan. When people were unable to consent, an assessment of their mental capacity was completed, but these did not provide clear information regarding the decisions and best interest recommendations as multiple decisions were recorded on one assessment.

People received support from appropriate health care professionals in order to maintain their health and wellbeing, including online advice from a virtual nurse computer system.

Staff were supported in their role through induction, regular supervisions and an annual appraisal. Most staff had completed mandatory training online; however a number of senior staff had not undertaken DoLS training.

People told us staff were kind, caring and treated them with respect. We observed people's dignity being maintained and people received support in a timely way.

Staff knew the people they were supporting well, including their individual preferences and choices. Care files provided information regarding people's preferred daily routines and some had a completed life history, enabling staff to understand people and their experiences.

A chapel was available within the home in order to meet people's religious needs. Services were held regularly and clergy from the local church also visited.

We observed relatives visiting during the inspection and they told us there were no restrictions on visiting. This encouraged relationships to be maintained.

Not all care files reflected that people had been involved in their development. All people we spoke with told us they were happy with the support they received.

The quality of information available within care plans varied. Some were detailed and reflected the needs and preferences of the individual; however others contained conflicting and inconsistent information about people's care needs. Care plans were not in place for all identified needs.

People told us they could choose how to spend their day and reported an increase in activities available recently. For people who chose to spend time in their rooms, call bells were available to ensure they could summon support from staff when required.

People had their views heard through the use of quality assurance surveys and resident and relative meetings. There was a complaints procedure in place and this was displayed within the home.

The quality and safety of the service was monitored through completion of audits by the manager and operational manager. These audits did not identify the concerns highlighted during the inspection. This meant that the process was not effective.

Not all incidents requiring the home to notify the care quality commission had been made.

There was a registered manager in place and people told us the home was well run and felt able to raise any concerns with the manager. People told us they believed they would be listened to.

Staff felt well supported by the manager and attended regular team meetings to enable them to share their

views.

Staff were aware of the homes whistleblowing policy and told us they would not hesitate to raise any concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Staff had received safeguarding training; however there was not an effective process in place to ensure all safeguarding referrals were made to maintain people's safety and wellbeing.

Medicines were not always managed in a safe way.

Staff were recruited in line with safe recruitment practices. There were adequate numbers of staff to meet people's needs and people told us they felt safe.

Risk assessments had been completed to monitor people's health, as well as the safety of the environment. Care was not always planned appropriately to meet people's identified needs.

The home was clean and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Deprivation of Liberty Safeguards (DoLS) applications had not been made for all people who required one. Not all staff had a clear understanding of which people had a DoLS authorisation in place.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed.

People received support from appropriate health care professionals to maintain their health and wellbeing.

Staff were supported in their role through induction, regular supervisions and an annual appraisal. Most staff had completed mandatory training on line; however a number of senior staff had not undertaken DoLS training.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and we observed people's dignity being maintained. People received support in a timely way.

Staff knew the people they were caring for well, including their preferences.

A chapel was available to people in order to meet their religious needs.

Relatives were able to visit without restrictions, encouraging relationships to be maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all care plans reflected that people had been involved in their development. All people we spoke with were happy with the care they received.

The quality of information available in care plans varied, some were detailed and reflected the needs of the individual, whereas others contained conflicting and inconsistent information.

People could choose how to spend their day and people told us there had been an increase in activities since an activity coordinator was employed.

Call bells were available for people in their rooms, enabling them to summon support from staff when necessary.

People were able to share their views through the use of quality assurance surveys and resident and relatives meetings. A complaints procedure was in place and displayed within the home.

Is the service well-led?

Inadequate

The service was not always well-led.

The quality and safety of the service was monitored through regular audits completed by the manager and operational manager. These audits did not identify the concerns highlighted at this inspection.

Not all incidents requiring the home to notify the care quality

commission had been made.

We received positive feedback regarding the management of the service and people felt able to raise any concerns with the manager. Staff felt well supported and attended regular team meetings.

Staff were aware of the homes whistleblowing policy and told us they would not hesitate to raise any concerns.

Thornton Hall and Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 16 and 17 December 2015 and 12 February 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed the information we held about the home. We looked at the notifications the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spoke with the registered manager, unit manager, seven members of the care team, seven people living in the home, four relatives, one visiting health professional and a visiting member of clergy. During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care files for seven people living at the home, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some people's bedrooms, bathrooms, the dining rooms and lounge.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Thornton Hall and Lodge and staff and visitors we spoke with agreed. One relative told us, "I never worry about anything, I know [relative] is safe here, any problems they [staff] would let us know."

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. All staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. Staff told us, and training records confirmed that staff received safeguarding training to make sure they were up to date with safeguarding procedures. There was a safeguarding policy in place which provided contact details to enable referrals to be made to relevant organisations.

Although there was a record of safeguarding referrals that had been made to the local authority, records we viewed showed that a number of incidents had occurred within the home which should have been referred to the safeguarding team, but had not been. For instance, one person's behaviour observation charts recorded a variety of incidents that should have been reported to the safeguarding team. This person's records showed that the home had contacted the local authority about similar incidents in August 2015 and observation records were implemented, however the regular incidents after this had not been reported. We spoke to the manager about this, who agreed to ensure relevant referrals were made immediately and on the second day of inspection, the manager confirmed these had been made. The manager also agreed to discuss safeguarding scenarios with staff to ensure they are aware of all incidents that need to be referred to the local authority safeguarding team. This meant that there was a risk people may not be protected from abuse as an effective system was not in place to report all relevant incidents.

On the third day of inspection, the manager told us they issued an update to staff to update them on incidents that should be reported, importance of observations and preventing potential incidents between people living in the home and that one staff member was to be in the lounge within the dementia unit at all times. We observed that staff had signed to confirm they had received this update.

The manager had also implemented a new system whereby staff reported all incidents they had recorded on the behaviour charts to the manager, to identify any potential incidents that should be referred to the safeguarding team. On the third day of inspection we observed a number of charts that the manager had signed to confirm they had reviewed the information. We found however, that further incidents had occurred that should have been reported to safeguarding, but had not been. The manager had reviewed and signed one behaviour chart that reported an incident which involved one person living in the home hitting another person living in the home, but this had not been reported to safeguarding. This meant that the systems implemented to ensure relevant safeguarding referrals were made; was failing. The manager agreed to make the safeguarding referral and source further safeguarding training for staff.

This was a breach of Regulation 13(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. The provider had not ensured the safe management of medicines in the home.

A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink). Stock balances were checked each week to enable medicines to be ordered in a timely way so that people had access to their medicines at all times. Managers also completed a number of audits each day to check medicines had been administered safely. Records showed that staff had completed training in the safe management of medicines.

Medicines were stored securely in trolleys attached to the wall, in a locked medicine room. Medicines that required refrigeration were stored within a medicine fridge; however the temperature of the fridge had not been recorded since August 2015, despite medicines being stored within it. Recorded temperatures we viewed were regularly not within the required range for safe storage of medicines and staff we spoke with were unaware of what temperature the fridge should be. This meant that refrigerated medicines may not work properly if they aren't stored in line with the current relevant guidance. On the third day of inspection, we found that the fridge temperature was within safe limits and although not recorded daily, recently documented temperatures were also within range.

We found that one medicine stored in the fridge had expired a week earlier but was still being administered, despite a new stock being available. The manager contacted the pharmacist for advice regarding this during the inspection, to ensure no harm would come to the person who had received this medicine. The out of date medicine was discarded immediately.

Medicines were managed through a computer system, which recorded people's name, photograph and any allergies in line with safe administration guidance. Electronic MAR charts recorded what medicines people were due and when, any medicines carried forward from the previous month, those returned and also provided a running balance of the number of each medicine in stock.

One MAR chart we looked at showed a medicine had been entered on the electronic record twice in error and had been signed by staff as administered twice. It was difficult to establish whether this medicine had been given as prescribed as the electronic balance did not match the actual stock available in the trolley. The manager agreed to look into this discrepancy and commence more regular checks to ensure people received the medicines as they were prescribed. On the third day of inspection, we found that the manager had implemented a new audit system and they told us they had undertaken further training in auditing the electronic medicine system. We checked the stock balance of five medicines on the third day and found that two of the balances were inconsistent with the amount the electronic system stated should be available.

Arrangements in place for administering medicines covertly (hidden in food or drinks without the person's knowledge) were reviewed. Medicines are generally only administered in this way if the person actively refuses medicines that are required to maintain their health and wellbeing and they lack the capacity to understand the consequences of refusing them. Decisions to administer medicines covertly in a person's best interest should include relevant health professionals such as the person's doctor and pharmacist, and be made in line with the principles of The Mental
Capacity Act 2005. This is legislation to protect and empower people who may not be able to make their own decisions.

The records we viewed showed that one person was receiving their medicines covertly, however the required agreements were not in place. Although an assessment of the person's mental capacity had been completed regarding medicines, it lacked detail and had not been completed by the most relevant person; who in this instance would be the person's G.P. This was necessary to show whether the person understood or could make decisions regarding their medicines. Although the GP had been contacted by the home a number of times, no authorisation had been received from the GP and there was no evidence that it was in the person's best interest to administer medicines in this way. The G.P had provided information on what medicines could be crushed or changed to liquid form. This meant that medicines were not being administered in line with current guidance and legislation. The manager contacted the GP during the first day of inspection to request a meeting to discuss the person's medicines. On the third day of inspection, we reviewed the arrangements in place for this person, but they had not changed. The person was still receiving covert medicines and the principles of the Mental Capacity Act had not been followed.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place.

The care files however, showed that care was not always planned appropriately to meet people's needs. One care file we viewed did not contain a plan of care to guide staff on how to manage a person's behaviours effectively. The plan recorded that the person could be uncooperative at times and there were a number of incidents recorded when the person's behaviour had become challenging. The care plan only guided staff to offer reassurances at these times, it did not advise how to effectively support the person when they presented with behaviours that were challenging. Staff we spoke with described ways they managed this behaviour, such as through the use of distraction techniques and staff had a good understanding of what worked for the individual; this was not, however, recorded.

On the last day of inspection, the manager told us they had implemented more frequent care file audits. The manager had reviewed one person's care and realised staff were not administering their medicines prescribed as and when required, to support the person with their behaviour. The manager stated the person displayed clear behaviours before becoming more agitated and administering the medicine at an early stage, reduced the distress and agitation the person experienced. Staff had began administering the medicine in this way which had had a positive effect on the person, however there was no care plan in place to support this.

This was a breach of Regulation 12 (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We looked at how the home was staffed. On the first day of inspection there were two managers, one deputy manager, three senior care staff and nine carers, supporting 47 residents in the home. Most people we spoke with told us there were adequate numbers of staff available to meet people's needs. One person living in the home told us, "There's always enough staff around so if you need anything you just need to ask and they are over." One staff member told us it can be busy at times, depending on the needs of the people living in the home and another staff member told us it can be busy when staff phone in sick at short notice, but overall there were enough staff. The manager told us they were currently recruiting to cover vacancies and were trying not to use agency staff to ensure consistency of care. A new extra care role had recently been implemented to cover sickness and holidays and to provide extra support during busy periods of the day.

We found that dependency assessments were completed for each resident and the manager told us these were used by the operational manager to calculate the required number of staff.

Our observations showed us there were adequate numbers of staff on duty. We observed continual staff presence within communal areas throughout the inspection and during lunch, enough staff were available to provide the required support to people in a timely way.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found that there was an effective procedure in place to recruit staff.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. Safety checks of equipment and services had been undertaken, such as weekly fire alarm tests, gas and electrical equipment, hoists and slings, call bells, water temperatures and window restrictors.

Checks had also been completed in relation to legionella and asbestos to ensure the environment remained safe for people living in the home. There was a system in place to report any maintenance work required. Staff had access to a maintenance book to log any repairs and this was signed by the maintenance staff once the work had been completed. This ensured the home remained in a good state of repair.

On the first day of inspection, we found a sluice door was unlocked and had chemicals stored within. There was also a cupboard in one of the dining areas that had no door but contained chemicals. This meant that people may be exposed to the risks of chemicals hazardous to health. The manager was notified and immediately ensured the chemicals were stored securely.

We found that accidents and incidents were recorded appropriately, though actions taken following the event were not always clear. A log of all accidents was maintained and reviewed each month to identify any trends or themes. This enabled appropriate measures to be taken to prevent recurrence. The manager told us that due to a recent incident within the home, policies had been reviewed and referrals to the falls prevention team were now made if any individual had more than two falls. We observed completed referrals to the falls prevention team and this was also indicated in the management report section within the accident forms, which provided information on any actions taken following the incident. Care files also contained a copy of the process to follow should the person sustain a fall.

People we spoke with did not have any concerns regarding the cleanliness of the home. One person living in the home told us, "I see the cleaning staff around every day so everywhere is kept clean." We found the home to be clean and this included communal areas such as the dining rooms, bathrooms, lounges and corridors. Staff were observed to wear personal protective equipment when serving meals at lunchtime and a stock of gloves and aprons were available to staff in relevant areas around the home. Liquid hand soap and paper towels were available in bathrooms in line with infection control guidance. Monthly infection control audits were completed and staff undertook regular competency assessments to ensure their hand washing was effective.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

On the first day of inspection the manager told us they had made six urgent DoLS applications, but felt that all people living within the dementia unit should have a DoLS application completed. The manager told us this had not been completed as the local authority had asked them not to send in all applications at once. No applications had been authorised at the time of the inspection. We found that although staff had an understanding of what DoLS was, not all staff were aware of whom DoLS applied to as staff we spoke with believed varying numbers of people had an authorised DoLS in place. Staff we spoke with told us they had completed DoLS training; however the training matrix provided to us showed that a number of senior staff had not completed this training.

During the inspection we observed two people pushing doors and trying to use the door keypad in an attempt to leave the building. We also heard another person regularly asking to go out but was not supported to do so, staff utilised distraction techniques to divert the person's attention instead. This meant that there was a risk people's liberty may be restricted unlawfully. We spoke with the manager regarding this and on the second day of inspection, the manager confirmed three DoLS applications had been made that day and they would ensure referrals were made for all people who required one.

On the third day of inspection, we reviewed the DoLS applications that had been made. Eight applications had been made in total and one authorisation was in place. We viewed records which showed that one person had been attempting to leave the home for a number of months and on one occasion had left the home and police were contacted to help find the person and bring them home. Despite this, a DoLS application had not been made and the person was being deprived of their liberty unlawfully. The manager agreed to apply for an urgent DoLS referral immediately. The manager told us there were still a number of people who required DoLS applications be made and they had contacted the local DoLS team who advised the manager to put in all relevant applications. These however, had not been completed.

This was a breach of Regulation 13(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During discussions with staff they told us they always asked for people's consent and we observed this during the visit. For instance, before entering a person's bedroom, providing personal care and cutting up a person's meal. Records we viewed showed that consent was not always gained consistently. Some care files

we viewed contained evidence of consent regarding photographs, access to records and family involvement. Another care plan however, reflected that the person lacked capacity so a form was signed by a staff member, stating all staff would act in the person's best interest regarding decisions relating to their daily care. The record stated that a lasting power of attorney(LPA) was due to be implemented in April 2015, but there was no information to advise who had applied for this or whether it was now in place. An LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. Other care plans contained consent forms that were blank.

On the first day of inspection, we found that when people were unable to provide consent, mental capacity assessment forms were completed, however they related to several aspects of care provision in one document, including personal care, diet, medicines, mobility, social interests and third party treatment. One best interest form was then completed so it was difficult to establish which decision the best interest actions related to. Two people's best interest decisions identified that DoLS applications were required, however the manager confirmed these had not yet been applied for. This did not follow the principles of the MCA.

On the last day of inspection, we reviewed mental capacity assessments within care files. We found that decision specific capacity assessments were in place and care plans guided staff how to provide support to people in their best interest. This process however was not always implemented consistently. For instance, we viewed one care file which reflected a person did not want to live in the home, but a mental capacity assessment had not been completed to establish if they were able to make this decision.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, district nurse, social worker, community psychiatric nurse, physiotherapist, dietician and falls prevention team. A chiropodist was also visiting on the first day of the inspection. The home had access to a "virtual nurse" computer system, which enabled staff to contact nurses for advice when necessary. This was achieved through computerised video technology and staff told us they found it very helpful, especially if a person felt unwell or had experienced a fall. The nurse would be able to see the injured person and give advice on their care and treatment needs. Accident reports reflected that advice was sought from the virtual nurses regularly.

We looked at personnel files to establish how staff were inducted into their job role. Records of induction were seen and we were told that new staff shadowed more senior staff until they felt confident. Staff we spoke with told us their induction also included completion of mandatory training and all staff told us they felt the induction was sufficient to enable them to meet people's needs.

We looked at ongoing staff training and support. We were provided with a training matrix which included training in areas such as dementia awareness, MCA and DoLS, nutrition, fire safety, first aid, food safety, health and safety, infection control, medicines, moving and handling and safeguarding. Most training was up to date, however not all relevant staff had attended MCA and DoLS training. Staff told us they completed annual e-learning and received some face to face training, such as moving and handling. One staff member had completed train the trainer and staff we spoke with found this a great support on a daily basis. Staff told us the training was adequate to ensure they had the required knowledge to care for people safely. One relative told us, "From what I have seen the staff seem to know their jobs so they must be very well trained."

Staff we spoke with told us they felt well supported and were able to raise any issues with the manager or senior staff when required. Staff told us they received regular supervisions and an annual appraisal to support them in their role. The personnel files we viewed contained records of the completed supervisions and appraisals. The manager told us they provided supervisions based on the needs of staff, and staff told us, "I have been supported really well and I appreciate it" and "They give me all the support I need." This meant that there was an effective process in place to support staff and enable them to meet people's needs.

We observed the lunch time meal in the Lodge dining room. People could choose where to eat their meal, either in the dining room or in their bedroom. In the dining room people sat together to eat their meal and staff were available at all times to provide support to people when required. There was a choice available for both the main meal and the dessert and a menu was available on the wall. There was a relaxed atmosphere during lunch and music was playing in the background.

When asked about the food people told us ,"The food is lovely, if you don`t like something you can ask for something else," "The food is fantastic" and a relative told us, "I have not had a meal here but I have seen the food and my [relative] always eats it all."

We observed the kitchen area and found that kitchen staff had access to information regarding people's dietary needs and preferences.

We observed the environment of the home and found that the manager had made adaptations towards the environment being appropriate for people living with dementia. There were pictorial signs on some bathroom doors, as well as coloured doors, handrails, coloured toilet seats and green crockery in the dining room. This helped enable people living with dementia to maintain their independence. The manager advised us this work is still ongoing and further improvements would be made in this area. We discussed use of pictorial menus so people with dementia could see what choices were available and following the inspection, the manager has advised these are now in place.

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. One person told us, "I know all the carers very well and they all know me, they are all very patient." The carer's were described as, "The best," "All lovely," "Fantastic" and "Very nice." Relatives we spoke with also agreed and told us, "I can't praise them enough, I think the staff are absolutely amazing" and "[Relative] is so happy and we would never move her from here, the carers are so professional." Staff told us they care for people like they would a member of their family.

A visiting health professional told us, "This is one of the best care homes I visit and the staff are really caring."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering and referring to people by their preferred name. Personal care activities were carried out in private and people did not have to wait long if they needed support. People were given plenty of time to eat their meals; they were not rushed in any way. Staff we spoke with were able to share examples of how they maintained people's dignity and records we viewed showed that most staff had completed dignity training.

Staff we spoke with knew the people they were caring for well, including their preferences. One staff member had given up their day off to support a person to go out and see the Christmas lights as they knew this was what they enjoyed. Care plans also provided details regarding people's preferences, in areas such as daily routine, activities and meals. One care file we viewed had a completed life history, enabling staff to get to know and understand people and their experiences.

Care plans we viewed showed that when able, people had been involved in the development and review of their care plans. The manager told us people's relatives were invited to six monthly care plan reviews to ensure they were aware of the plan in place and care files recorded contact with people's relatives. One visitor we spoke with confirmed that they had been involved in the plan of care for their relative.

People's needs in respect of their religion and beliefs were understood and met by staff. There was a chapel within the home that was accessible to people at any time and a weekly catholic service was conducted, as well as a monthly church of england service. People we spoke with were aware they could visit the chapel if they chose to.

We observed relatives visiting throughout both days of the inspection. The manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us they could have visitors at any time and visitors we spoke with agreed.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home. There was nobody in the home receiving advocacy services

at the time of the inspection but the manager told us these had been accessed in the past and staff were aware of how to make a referral if necessary.

Requires Improvement

Is the service responsive?

Our findings

We looked at how people were involved with their care planning. Some records we viewed showed that when people were able, they had been involved in developing their care plans and people had signed to evidence their agreement with the plans in place. Other files did not contain completed consent forms, or any other record to evidence the person's participation or consent to their care plan. A relative told us they were involved with the development of their relative's care plan when they first moved to the home and staff kept them informed of any changes. All people we spoke with told us they were happy with the care they received. One person told us, "I am well looked after here."

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs. One staff member told us "We always start with a handover so we know what's happening which makes sure we all know what needs to be done during our shift." Senior carer's also utilised a communication book to ensure staff were kept informed of any changes.

Care plans we looked at provided information in areas such as skin integrity, personal care, medicines, mobility, nutrition and cognition. We found differences between the quality of information recorded within plans and how individual they were to the person. For instance, one care plan regarding personal care, did not advise how the person wanted to be supported, or what they required staff to support them with. A second care file contained a personal care plan that reflected the individuals support needs as well as their preferences, such as the use of roll on deodorant rather than spray. The manager felt that this was due to different staff completing the care plans and said they would ensure all staff receive guidance on writing care plans which are individual to the person. This would help ensure staff were aware of people's needs and preferences, even if people were unable to inform staff themselves.

We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission. Some care plans provided detailed information regarding the support a person required. This ensured staff were aware of their individual needs, so they could be met effectively. For instance, one nutrition care plan advised that the person needed to sit upright for 30 minutes after eating to reduce the risk of aspiration. Aspiration is when food or fluids enters a persons lungs.

Although the care plans we viewed were reviewed regularly, they did not always reflect the person's current needs. For instance, one care plan recorded that the person slept well all night, yet one of the reviews reflected that the person, "Continues to have a poor sleep pattern and wakes continuously during the night." Another care plan reported that a person required support with their mobility, the review stated that the person's mobility was limited and notes from a physiotherapist reflected that the person was unable to mobilise and could only transfer. This provided conflicting information regarding the person's mobility needs. The manager agreed to ensure care plans were updated to provide clear and consistent information regarding people's care needs.

We asked people to tell us about the social aspects of the home. Some people we spoke with told us they

chose not to participate in activities. Minutes from a residents and relatives meeting in July 2015, reflected that people did not feel there were enough activities available. One person told us, "We don't do many activities but I think someone new has started so maybe that will change." One relative told us there had been a recent increase in the amount of activities available. Staff told us the halloween party had been a success as well as the recent christmas party that took place.

An activities coordinator had recently been employed to work monday to friday and we spoke with them regarding the activities available to people. The activities coordinator told us they were still getting to know what activities people preferred to participate in, but there were a range of activities available, such as games, arts and crafts, bingo and singing. These activities were displayed on a notice board so people could see what was available.

There was a hairdressing salon within the home and the hairdresser visited each week. A weekly luncheon club had been organised at a local church and some people we spoke with told us they attended this and enjoyed it. Staff supported people to access the local community in order to pursue activities that interested them, such as shopping or going to see the Christmas lights.

People told us they had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges, whether to join in activities or spend time in their rooms. Care files evidenced people's choice with regards to their daily routines, such as when to go to bed or get up of a morning. Staff told us they always ensured people had choice, and don't have set routines to support people; they offer support when required and ask people each day what they would like to eat.

We spoke with two people who chose to spend time in their bedrooms and they had access to a call bell to alert staff if they needed support. One person told us staff, "Always come quickly." Staff told us they checked on people in their rooms regularly to ensure their needs were being met and they were not becoming isolated.

People had access to a complaints' procedure and this was displayed on a notice board within the home. We looked at the complaints record, which showed that any complaints received, were addressed by the manager and that complainants were happy with the outcome. People we spoke with told us they did not have any complaints but would speak with staff or the manager if they did. People told us they would be listened to and one relative told us, "I've been coming here for a while now and I have never had to complain, but if I needed to I would just see one of the staff."

We viewed a file containing a number of thank you cards that had been written by relatives, thanking staff for the care they had provided to their loved ones.

There were monthly quality assurance questionnaires available within the home. Each month had a different topic, such as care, admission to the home and relatives views. We viewed a small number of completed surveys from this month and they contained mainly positive feedback. The manager told us they get sent to head office, which collate the information and provide a summary to be displayed in the home. One person living in the home told us, "I have done surveys, in fact I have just completed one" and a relative we spoke with had also completed a survey recently.

The manager told us and records we viewed, showed that resident and relative meetings took place regularly. People living in the home told us, "We have meetings every so often and families get invited as well, we had one not so long back" and "We have meetings every so often, a couple of times a year and they do listen to us." A relative we spoke with told us they had attended a meeting a few months ago.

Inadequate

Is the service well-led?

Our findings

We looked at how the manager and provider ensured the quality and safety of the service provided. The operational manager visited the home each month and we viewed completed compliance audits. These covered all aspects of service provision and identified actions for improvement when required. We viewed audits in areas such as falls, complaints, use of bed rails, pressure sores, skin tears, infection control and people's weight. These identified any actions required, such as referrals to relevant health professionals or risk assessments that needed to be completed.

There were audits in place for individual care plans; however these did not pick up the issues we identified in this area during the inspection, such as inconsistencies within the plans, the lack of care plans for specific care needs and recorded incidents that should have been referred to safeguarding, but had not been. We also viewed medicine audits which had highlighted some issues and recorded that they had been addressed; however, the auditing system did not identify the issues we highlighted regarding medicines. Accident forms were also audited each month, however they did not identify all incidents that should have been referred to the safeguarding team for investigation. This meant that systems in place to monitor the quality and safety of the service were not always effective and this had the potential to place people at risk.

On the third day of inspection we found that the manager had implemented more frequent care file audits which had identified issues, such as the lack of a care plan for a new medicine regime and highlighted when required plans of care were not in place, such as a mental capacity care plan. A new medicine audit had also been developed which the manager told us was more effective with the computerised medicine system in use. We were told that the manager was reviewing incidents recorded on behaviour charts to identify potential safeguarding issues, however we found some recorded incidents that should have been reported, but had not been. This meant that although some improvements had been made, the systems in place were still not effective and could place people at risk.

This was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found on inspection that some issues requiring the home to notify the Care Quality Commission (CQC) had not been made. These included notifications regarding allegations of abuse. Records showed that some incidents had been reported to CQC, however, a number of incidents had not. This meant that CQC would not have all required information to ensure potential risks regarding the service were identified and addressed appropriately. The manager told us they would ensure all relevant notifications were made.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People living in the home told us it was run well and one relative told us, "I think the home is very well managed, I feel involved."

Staff told us they were well supported by the management team and described them as, "Brilliant," "Approachable" and "Willing to listen to you no matter what." People living in the home and their relatives

agreed that they could approach the manager with any concerns. One resident told us, "The manager is lovely, all the staff are, could not get better." Relatives told us, "The manager is really down to earth, a hands-on manager" and "The managers are very nice and very professional, each time we visit they come over and have a chat, they really are good."

We looked at processes in place to gather feedback from people and listen to their views. As well as resident and relative meetings and quality assurance surveys, there were also regular staff meetings held to ensure views were gathered from staff. Records we viewed showed that staff meeting took place every few months and covered issues such as safeguarding, care plans and new ways of working.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue. Having a whistle blowing policy helps to promote an open culture within the home.