Regal Care Trading Ltd

Hawthorn Lodge Care Home

Inspection report

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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced inspection of the service on 9 and 10 October 2015. Hawthorn Lodge Care Home provides accommodation for persons who require personal care, for up to a maximum of 60 people. On the day of our inspection 48 people were using the service and there was a registered manager in place.

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

People were supported by staff who could identify the different types of abuse and knew who to report any concerns to. People told us they felt safe at the home and that there were enough staff to support them.

The risks to people's safety were not always appropriately assessed and well managed and were not always regularly reviewed. Parts of the premises and equipment

Summary of findings

were not managed appropriately to keep people safe. People had personal emergency evacuation plans (PEEPs) in place. Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the registered manager and were investigated. People's medicines were not always safely managed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS are part of the MCA. They aim to make sure that people are looked after in a way that does not restrict their freedom. The safeguards should ensure that a person is only deprived of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. The registered manager had applied the principles of the MCA and DoLS appropriately and was making further applications for more people to the authorising body.

People had access to external healthcare professionals however the guidance and recommendations made by them were not always implemented. People spoke positively about the staff and were supported by staff who received supervision and appraisal of their work. However these were not always completed often enough to ensure people received effective and consistent care and support. The majority of the staff training was up to date; however some staff required refresher training in some areas. The majority of the people we spoke with told us they liked the food and drink provided at the home. Limited adaptations had been made to the design of the home to support people living with dementia.

People felt the staff were kind and caring and treated them with respect. Information for people on how to access independent advice about decisions they made was not easily accessible. People told us they felt included in decisions made about their care and support although people's records did not always reflect this. People did not always have the privacy they needed. Some toilet doors did not have privacy locks on them and posed a threat to people's dignity. The language recorded within people's care plans was not always respectful. People were encouraged to do as much for themselves as possible and staff understood people's likes and dislikes.

People's care records contained an initial assessment of people's needs however they did not provide easily accessible guidance to staff to provide care that met their personalised needs. The current care planning system used a mixture of electronic and paper records and this resulted in some records not being appropriately completed. People's life history was not always recorded within their care records. Some people were not always able to get out of bed at the time they wanted to; although people told us they felt the staff responded well to their other needs.

People spoke positively about the activities at the home and felt confident in raising a complaint if the needed to.

The registered manager's auditing processes were not always used effectively and had not identified the issues raised within this report. The registered manager had not ensured that the CQC were always provided with the appropriate statutory notifications. People and staff spoke positively about the registered manager and staff understood the aims and values of the service. People were encouraged to become involved with development of the service and were given the opportunity to give their opinions during 'resident meetings.'

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this report.

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 consistently safe.

The risks to people's safety were not always appropriately assessed or reviewed. Parts of the premises and equipment were not always managed appropriately.

People's medicines were not always safely managed.

People were supported by staff who had received safeguarding adults training and knew who to report concerns to.

People had personal emergency evacuation plans (PEEPs) in place. Accidents and incidents at the home had been recorded, reported to the registered manager and investigated.

Is the service effective?

Requires improvement

The service was not consistently effective.

People had access to external healthcare professionals however people's day to day health needs were not always met.

Limited adaptations had been made to the design of the home to support people living with dementia.

Staff received supervisions and appraisal of their work but these were not always conducted regularly enough.

People received support from staff who had the right skills; however some staff required refresher training for some subjects.

The majority of the people liked the food and drink they received.

Staff applied the principles of the MCA and DoLS appropriately when providing care for people. Although there were a small number of examples where a MCA assessment was needed that were not in place.

Is the service caring?

Requires improvement

The service was not consistently caring.

Information for people on how to access independent advice about decisions they may make was not easily accessible.

People felt included in decisions made about their care and support although people's records did not always reflect this.

People did not always have the privacy they needed and on occasions this compromised their dignity.

People felt the staff were kind and caring and treated them with respect.

Summary of findings

People were encouraged to do as much for themselves as possible and staff understood people's likes and dislikes.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care records did not always provide easily accessible guidance to staff to support people's personalised needs. People's life history was not always recorded within their care records.

People's care records were not always appropriately completed, some records were missing and they were not always reviewed.

People and visiting healthcare professionals spoke positively about the activities at the home and felt confident in raising a complaint if they needed to.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The registered manager's auditing processes were not always effective and had not identified all of the issues raised within this report.

Statutory notifications had not always been sent to the CQC.

People and staff spoke positively about the registered manager and staff understood the aims and values of the service.

People were encouraged to become involved with development of the service and were given the opportunity to give their opinions during 'resident meetings'.

Hawthorn Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 October 2015 and was unannounced.

The inspection team consisted of three inspectors.

Before the inspection, we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law.

We spoke with fourteen people who used the service, two relatives, four members of the care staff, two domestic assistants, the cook, the administrator, the deputy manager, the registered manager and two representatives of the provider.

We looked at all or parts of the care records and other relevant records of seven people who used the service, as well as a range of records relating to the running of the service.

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.

Requires improvement

Is the service safe?

Our findings

The risks to people's safety were not always appropriately assessed and well managed. For example one person's care records had identified the person as having 'suicidal thoughts'. However we saw no risk assessment or care plan in place to ensure that staff were aware of the possible risks and how to support this person in a safe way. We raised this with the registered manager and they told us that this person was no longer at risk. However the appropriate documentation was not in place to show that the registered manager had carried out an assessment to determine that this person was not at risk.

There were other examples where risk assessments had not been reviewed. One person who was at high risk of falls had not had their falls risk assessment reviewed for six months and another person with the same risk for four months. The lack of risk assessments and their regular review increased the risk of people receiving care and support that was not appropriate for their needs.

We raised these issues with the registered manager. They acknowledged that more needed to be done to ensure that all people had the appropriate risk assessments in place and that when they were that they were reviewed regularly.

These examples could place the health and safety of people at risk. The registered manager told us they would address these issues immediately.

People told us they were happy for the staff to look after their medicines for them. One person said, "The staff take care of my tablets, I always get them at the right time." Another person said, "They look after our tablets for us, they bring them when we need to take them."

We observed a member of staff assist a person with their medicines. They were friendly and helpful, offered them assistance and gave explanations when needed. The person responded positively to the staff member. We looked at the arrangements for the safe storage and administration of controlled medicines and carried out stock checks of two controlled medicines. These were in line with requirements.

People's medicines were not always safely managed. We found medicines were stored securely in a locked trolley and locked cupboards; however, the required temperature checks of the storage areas were not always recorded. To ensure the effectiveness of people's medicines is not compromised they must be stored at the appropriate recommended temperature. The lack of recorded temperature checks meant the registered manager was unable to confirm whether they had been stored safely.

We looked at Medicines Administration Records (MAR) and found they had not been completed consistently. Photographs, allergies and people's preferences in relation to taking their medicines were not always noted. There were gaps on some of the records to show whether people had received or refused their medicines. A person's records did not record where a specific type of patch had been administered. This was important as the placement of the patch on the person's body needed to be varied to ensure it was effective. There were also gaps for a person who required their medicines at a set time and a person who required eye drops did not always receive them. One person had received an incorrect dosage of their medicine on a number of days. We raised these issues with the registered manager. They told us as matter of urgency they would review these concerns and the records for all people within the home to ensure they accurately reflected the medicines that people received.

People's records did not contain protocols to provide additional information for staff on the reasons for giving medicines which were prescribed to be given only when necessary. This could mean staff did not administer these types of medicines in a consistent way which could place people's safety at risk. We also found incorrect stock levels for a medicine used as a tranquilizer which meant we were unable to assess whether this person had received this medicine appropriately and in a safe way.

The registered manager told us they would make the relevant referrals to the local authority safeguarding team regarding some of these concerns. We were advised by the registered manager after the inspection that they had done so.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Parts of the premises and equipment were not always managed appropriately to keep people safe. We saw that harmful liquids were stored in a cupboard which had been left unlocked and unattended. The upstairs and downstairs laundry rooms' doors were shut but not locked so they

Requires improvement

Is the service safe?

could be accessed easily. We found large industrial detergent bottles on the floor in both rooms. This meant that there was a risk of people being exposed to harmful liquids. Some radiator covers were not securely fixed and could come loose from the wall which could cause people harm. Records showed that a hoist, used to assist people who could not move themselves, had a service date of July 2015. This had not been completed. Records also showed that the fire detection systems, such as smoke alarms were due to be assessed in September 2015. This had not been completed.

The nursing call bell system used by people to request assistance from staff was not always working appropriately. We were told by the registered manager that the system does on occasions show that a bell had been pressed in a room when it had not been. They told us they had requested external contractors to fix this issue.

People had personal emergency evacuation plans (PEEPs) in place. People's needs had been assessed in order for staff to be able to evacuate them safely in case of an emergency. These were regularly reviewed to ensure they were appropriate to people's current health and needs. A business continuity plan was in place which contained information on how people's safety would be maintained if there was a loss of power, water or a gas leak.

Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the registered manager. The registered manager told us they reviewed the incident reports and made recommendations to staff to reduce the risk of these incidents happening again. The registered manager told us they analysed the types of accidents and incidents that occurred and then where needed requested external reviews from health and social care professionals. The records we viewed reflected this.

People told us they felt safe living at the home. One person said, "I feel safe and secure." Others told us they felt their belongings were safe at the service.

The risk to people's safety was reduced because the staff who supported them had attended safeguarding adults training, could identify the signs of abuse and knew who to report concerns to both internally and to external agencies. A safeguarding adults policy was in place.

Information was available for people on how they could maintain their safety and the safety of others. This included how to report concerns if they felt they or others had been the victim of abuse. However this information may prove inaccessible for some people as it was provided in the foyer, which was behind a locked door that required an access code to open. We raised this with the registered manager and they told us they would ensure this information was made more easily available for people.

People told us they thought there were enough staff to keep them safe. However some stated that they would like the staff to be more consistent with the time they said it would take to return to them when they were supporting others. Another person said, "If I wasn't getting looked after well enough then I would shout about it. Everything is fine, no problems." Another person said, "I feel as though I get well looked after. I know sometimes I have to wait [for staff to support them] but all in all it isn't bad."

The majority of the staff we spoke with told us they thought there were enough staff to enable them to carry out their roles and maintain people's safety. Records showed the registered manager had carried out regular assessments of people's dependency needs and ensured there sufficient numbers of staff to meet those needs.

We looked at the recruitment files for three members of staff. All files had the appropriate records in place including; references, details of previous employment and proof of identity documents. We also saw criminal record checks had been conducted before staff commenced working at the service. These checks enabled the registered manager to make safer recruitment decisions reducing the risk of people receiving support from inappropriate staff.

Requires improvement

Is the service effective?

Our findings

Care records showed that other health and social care professionals were involved in people's care as appropriate to support staff in managing their day to day health needs. However, a visiting healthcare professional told us that staff had not recorded that they were assisting a person to change their position in line with their guidance to minimise the risk of skin damage. We checked their care records which did not show that any positional changes had taken place for one 24 hour period. A care plan to address these concerns had not been put into place until five days after the recommendations by the visiting professional. This placed the person's health at risk. We raised this with registered manager. They told us they were unaware at the time that a care plan had been requested for this person and stated there had been a breakdown in communication between the staff. They told us there was now one in place. They also told us they would put a process in place immediately to ensure that recommendations made by visiting health care professionals were put in place as soon as possible.

The visiting healthcare professional also raised concerns that they had requested a sleep chart to be put in place to monitor the sleeping pattern for a person. This had not been done. They also asked for the person's weight to be monitored and a risk assessment to be put in place to address the concerns. This had also not been done. The registered manager told us they would review and ensure the appropriate processes were put in place.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was guidance in place for staff to support people with their healthcare needs. For example, people living with diabetes were supported by staff who were provided with the appropriate guidance on how to support them safely and effectively if they had a hyperglycaemic or hypoglycaemic seizure. These seizures occur when a person's blood sugar levels are too high or too low.

People had access to their GP and other external healthcare professionals when needed. A GP visiting the home at the time of the inspection told us they had no concerns in relation to their patients. The GP also spoke highly of the staff and of one staff member in particular who they described as; "Very caring towards the residents. They ask good, relevant questions [when the GP visits.]"

People spoke positively about the staff and felt they understood their health needs. A visiting health care professional told us some of the long standing members of staff, particularly senior staff, were very knowledgeable and skilled.

We saw plans were in place for new staff to commence a new nationally recognised qualification called the 'Care Certificate'. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives people who use services and their friends and relatives the confidence that the staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Records showed staff had completed sufficient training in order for them to carry out their role effectively and to support people in line with their assessed needs as recorded within their care records. One member of staff said, "I feel well trained for the job. When new staff start we all get updates on training to help us keep up to date." Training had been completed in key areas such as moving and handling. However we did find a small number of staff who required refresher training in areas such as the safeguarding of adults.

People were supported by staff who received supervision and appraisal of their work. These were carried out to ensure that staff provided consistent and effective care for the people they support. However records showed that these were not always conducted in a timely manner. Some staff had not received supervision for a period of over five months. One staff member described the frequency of the supervisions as "sporadic"; however they did feel supported by the registered manager. The registered manager acknowledged that supervisions needed to be conducted more often and planned to delegate the tasks of completing some of the supervisions to the deputy manager or senior care staff.

People were supported by staff who understood their needs and had the required skills to meet these needs. We

Requires improvement

Is the service effective?

observed staff interact with people effectively throughout the inspection. They showed a good understanding of people's preferences and choices and ensured wherever possible they accommodated people's wishes.

Where people lacked the mental capacity to consent to care and treatment, we saw processes were in place to ensure that the principles of the Mental Capacity Act 2005 (MCA) were adhered to. The MCA is legislation used to protect people who might not be able to make informed decisions on their own about the care and support they received. The staff we spoke with had varying knowledge of how they would incorporate the MCA into their role.

We saw some assessments of capacity and best interests' documentation were in place where required, however we also found examples where they were not. For an example a person was receiving their medicines covertly but the appropriate MCA assessment was not in place. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication. This meant decisions may be being made for people by staff who do not fully understand the principles of the MCA and the appropriate legal process had not always been applied.

People were supported by staff who gave them choices and respected their wishes. We saw some good examples of staff communicating effectively with people to ensure they understood what was being asked of them and then waiting for a response. However we also saw some poor practice. A staff member pulled a person's wheelchair from behind when moving them from the dining room table. They did not explain that they were going to do this before they did or ask the person if they wanted to move.

There were some examples in people's care records that showed people were supported to make decisions for themselves and where they were unable to, relatives with the legal authority to act on their behalf had been consulted. We saw examples of people giving their consent either through a signature or reference to verbal consent being recorded in their care records.

We checked whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. DoLS were in place for some people who needed them and the registered manager had identified others who required these safeguards to be put in place. Records showed they had made the appropriate applications to the authorising body.

In some people's care records their wish to not have life-saving treatment if it were to have a detrimental effect on their on-going health was recorded. The documentation had been completed either with their consent or if they lacked capacity to do so, by an appropriate person.

The majority of the people we spoke with told us they liked the food and drink provided at the home. One person said, "There is nothing wrong with the meals they are lovely. You get a choice of two things every day. They [staff] come round at about half past eleven to ask what you want. There are plenty of drinks and snacks if you want them." Another person said, "The food isn't perfect, but it isn't bad at all."

We observed the lunchtime experience on both days of the inspection. On day one of the inspection the serving of the meal was slow and many people were kept waiting for their meal; some as long as half an hour. The registered manager told us the delay was due to the overrunning of a staff meeting. One person who used the service said, "Normally you sit down and the food is here straight away." On day two, the lunchtime experience was more planned with people receiving their food in a more timely manner.

People were offered the choice of where to sit. People had their food served to them and were encouraged by the staff to eat independently. Where needed, people were provided with specially adapted equipment to enhance their ability to eat independently. Where people required more support this was provided by the staff.

People who had specific dietary requirements, as a result of their cultural or religious background, or specific health condition such as diabetes, were supported to have the appropriate food and drink to meet their needs.

People who had been assessed as being at risk of dehydration, malnutrition or excessive weight gain or loss had plans in place to support them. We saw food and fluid monitoring charts were in place to record the amount of food and drink that people consumed. We looked at a sample of these records. The fluid intake for some people was between 700-800ml a day which would be regarded as low and could place people at risk of dehydration. The

Requires improvement

Is the service effective?

registered manager told us they were certain people received enough to drink and believed the staff had not completed people's records appropriately. They told us they would address this with the staff.

The registered manager told us there were at least twenty people living at the home who were living with varying forms of dementia. Limited adaptations had been made to the design of the home to support people living with dementia which could have an impact on their ability to lead as independent a life as possible. Some of the toilets and communal rooms on the ground floor were identified by signs and symbols, however, there was little directional signage to aid people to orientate themselves or to enable them to move around the home independently. This was most prominent on the first floor. Most bedrooms did not have people's names, photos or other memory aids to support people to independently access their own bedroom. A small number of people had memory boxes outside their bedrooms to help them identify their room, but for others this assistance was not available. The registered manager told us they were aware of this issue and had ordered some new signs to be placed around the home to improve people's ability to move independently around the home.

Requires improvement

Is the service caring?

Our findings

People spoke positively about the staff who supported them. One person said, "It makes me happy being here. I feel like my family are in this place." Another said, "The [staff] here get on ever so well with me. They look after you here. I have a laugh with them."

People told us they felt able to speak with the staff about their care. However information to support people if they wished to speak with an independent advocate was not easily accessible. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. The information was placed in the foyer of the building which was behind a locked door. This may prove difficult for some people to access.

The registered manager told us they had previously invited representatives of Age UK (a charity dedicated to helping older people lead as fulfilling a life as possible) to attend the home to provide people with information about the services they could offer people. The registered manager acknowledged that as this was a while ago, more, easily accessible information was needed for people to ensure they could access the information they needed.

We observed people were provided with information about their care and support needs throughout the inspection. However, we saw little recorded evidence of this within people's care records and some people told us they had not seen their care records. The registered manager told us they would remind staff when carrying out reviews or when a discussion had been held with a person about their care that is was recorded within their care records. They also told us they would offer people the opportunity to see their care records if they wished to.

People were not always provided with the privacy they needed and at times this placed their dignity at risk. The toilets on the ground floor near the reception area did not have a privacy lock on them and we saw people being disturbed whilst using the toilet. We raised this with the registered manager and they told us they would ensure locks were put in place immediately. Other toilets throughout the home did have locks in place.

We identified a person who spent a lot of time alone in the upstairs television lounge. The registered manager told us the person like to spend time on their own. However, throughout the inspection we checked on this person and established there were periods of time when they had not been checked by staff. For example in the afternoon when their lunch had been served to them in the television lounge we saw the person's plate was still in front of them three and a half hours later. The person's care records showed no staff involvement during this time. This would indicate that the person was not checked during this time. The registered manager agreed that the staff should have checked this person more regularly.

We looked in more detail at this person's care records. We saw one entry made by a member of staff which stated, 'We have told [name] off for shouting.' This language showed a lack of respect for this person. We raised this with the registered manager and they agreed that this type of language should not be used when talking with people and they would ensure the staff were reminded of this.

Other people told us they felt they were treated with dignity and respect and the staff regularly checked on them to see if they were ok or needed any assistance. One person said, "Every five minutes someone is popping in to check if I am ok and have a chat. If I feel better I go into the lounge, but if I am in here they make sure I am ok."

Information was available for people throughout the home which explained how they should expect to be treated with dignity at all times. Dignity Champions were in place. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

The staff were kind and caring and ensured people were treated with respect. One person who used the service said, "The staff are very kind, they are lovely, very attentive." However we also some examples when staff did not assess the impact their actions could have on people. For example, we observed a member of staff start vacuuming in the activities room where a person was sitting alone, eating their lunch. The staff member vacuumed right in front of them. The person held their head in the hands and looked distressed. We raised this with the registered manager. They told us they would discuss this with the staff member and put a plan in place to ensure that vacuuming and other cleaning was not done when people were eating and was also done at a more suitable time of the day.

Staff encouraged people to do as much for themselves as possible to increase their independence. One person said,

Requires improvement

Is the service caring?

"I am fully independent, I don't need any help with care at all. If I had a fall in my flat then I would ring the call bell." We observed staff support people with the use of walking aids, to attend toilets on their own and to choose where they wanted to sit and eat. The care records that we looked at showed some discussions had been held with people or their relatives where appropriate, to establish their level of independence and how they wanted to staff to support them to be as independent as they wanted to be.

We talked with staff about the people they cared for. They understood people's needs and preferences and could explain how they supported people. The care staff had a natural rapport with people and a light hearted approach, encouraging people to ask for help when they needed it and chatting with them about their plans for the day. They responded to people's distress or discomfort in a timely manner and reassurance was offered when needed.

People told us they felt listened to and their views were respected. One person said, "Here you are treated as humans, staff are courteous."

Requires improvement

Is the service responsive?

Our findings

People's care records contained an initial assessment of people's needs however they did not provide easily accessible guidance to staff to provide care that met people's personalised needs. Records were a mixture of paper and electronic records. Electronic records showed that a number of care plans were missing for a number of people and paper records were disorganised so it was not clear whether this guidance was available. The registered manager told us they were in the process of transferring all records from paper to the electronic system. However they acknowledged the records did not always reflect the care and support that people received and could be confusing for staff.

Information on people's life histories and preferences was limited and not incorporated into all care records. We saw attempts had been made to record this information in some records but in others there were large gaps and omissions with no explanation as to why the information had not been recorded. This could make it difficult for staff to have a detailed knowledge of the people they supported in order to provide them with care that responded appropriately to their wishes.

People's care records were reviewed however they lacked detail about who was involved and whether any points had been discussed with people and been responded to appropriately. People told us they thought the staff responded well to them, but some people did tell us they had not

been involved with reviews about their care. The registered manager acknowledged that more was needed to be done to ensure that people were fully involved with the planning of their care and when changes were made, the care records were appropriately updated.

People's care records contained references to how people would like their personal care to be provided. This included people's preference for male or female staff to support them when personal care was being provided.

We also found examples where staff did not always respond appropriately to people's wishes. A person we spoke with told us, "Staff are very busy at times; it would be helpful if they gave me clear information about delays. When they tell you they will be 'back in a minute' when really it will be half an hour. I rang the bell to get up at 7.30am today but had to wait half an hour."

The registered manager acknowledged that there were occasions when people were unable to get out of bed at the time they wanted to. They said this was due to times when other people needed more urgent support. However they told us they would review this to ensure that people received the personalised care and support they wanted.

People told us they felt there were suitable activities at the home and were able to do what they wanted to do. One person told us they, "Had a good day out," at a recent trip to the seaside. Another person said, "They have music entertainers quite often and we go down and enjoy that." We were told that an activities coordinator worked full time at the home to support people with following their interests, although they were on holiday at the time of the inspection. One member of staff told us that since their appointment that has meant people were able to do a lot more than before.

We noted that the activities timetable did not contain reference to any activities taking place over the weekend. We raised this with the registered manager. They told us this was because many people had visitors and it was difficult to plan activities around this. However they assured us where people did not have visitors, or, if people wanted to do something that interested them, then this was arranged for them. The people we spoke with did not raise any concerns about a lack of activities over the weekend.

During the inspection a planned trip to a local attraction was planned. The registered manager had ensured that everyone who wanted to go could do so and planned the activity over a number of nights that week, transporting people via the home's minibus. This ensured that people were not excluded due to limited transport being available and ensured people were able to socialise with their friends outside of the home environment.

A visiting healthcare professional described the activities at the home as, "Top notch compared to other homes they visited." They also said they often saw people sat out in the garden when they arrived when the weather was good and that a lot of effort was made by the home to keep people busy and stimulated. We saw there was a rabbit which

Requires improvement

Is the service responsive?

people looked after and the registered manager's Labrador was also present. People responded very positively to the dog, making people smile whenever they came to them. One person described the dog as, "Absolutely wonderful," and they said they were so pleased that the dog visited the home as it made them so happy.

People were provided with the information they needed to raise a complaint. However the complaints process did not contain details of who to make a complaint to outside of the service, for example the phone number for the CQC. The people we spoke with understood how to make a complaint within the service and felt their concerns would be acted upon. Two people we spoke with said, "We have never had any worries or concerns." Records showed that the registered manager recorded people's complaints and acted on them in a timely manner.

Requires improvement

Is the service well-led?

Our findings

The registered manager had auditing processes in place to assess, identify and manage the risks to people who used the service. However these auditing processes were not always used effectively. They had not identified all of the issues raised with this report. These included the concerns regarding the management of people's medicines, the lack of risk assessments in people's care plans and the lack of care plans to address these risks.

A visiting healthcare professional raised concerns with us that they felt the service had declined over the past six months and was concerned recommendations by made by them had not always been put into place.

Although the registered manager had identified the need for staff to have a consistent approach to completing the newly formed electronic care planning system, this had not resulted in robust and effective recording processes. Many of the records we looked at did not always reflect people's current level of need and contained information that was in some cases years out of date. We observed a staff meeting where the registered manager discussed this with staff. There was confusion amongst staff on what was required of them. The registered manager explained to them what they expected of them, but at the time of the inspection many of the care records for people were not of sufficient quality to ensure people received consistent, safe and effective care and support.

These issues, along with the other concerns raised within this report increased the risk to people's health and safety.

These were examples of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were aware of their responsibilities to meet the conditions of their CQC registration. The CQC must be informed via a statutory notification if a person receives a serious injury or if they were being deprived of their liberty. We found three examples where these had not been completed. We were notified by the registered manager after the inspection that these had now been sent.

People and staff spoke positively about the registered manager and commented on the open, caring and friendly approach they had to managing the service. One person said, "The manager is there if we need them. We can go into the office anytime." A staff member said, "[The registered manager] is very caring to all the residents here, she really does care about them." We saw information in the reception area that encouraged people to speak with the management team and throughout the inspection we observed the registered manager interact positively with all people who used the service and their relatives.

People were supported to access the local community and to meet with people from other services. For example a bonfire night event was in the process of being planned with another adult social care service. The registered manager told us, "This helps people build on-going relationships with others within the local community." The people we spoke with told us they were able to access their local community if they wished to.

The staff we spoke with could explain the aims, values and goals of the service and how they incorporated them into their role to provide people with safe and effective care and support. One member of staff said, "The residents are number one, we're here to help them to do what they want and to lead as fulfilling a life as possible." The staff we spoke with also understood the whistleblowing process and knew who they could report their concerns to externally if they needed to.

People were encouraged to become involved with development of the service and were given the opportunity to give their opinions during 'resident meetings.' The registered manager could explain changes they had made as a result of the feedback provided. They also told us they planned to introduce a more formal approach to obtaining people's feedback by giving people the opportunity to complete an anonymous questionnaire.

The registered manager told us they held regular staff meetings to discuss the risks to people and the service as a whole and how they could contribute to reducing those risks. A member of staff said, "The manager always explains what is expected of me and what needs to be done."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not always; (a) assess the risks to the health and safety of service users of receiving the care or treatment; (b) do all that is reasonably practicable to mitigate any such risks; (d) ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; (g) ensure the proper and safe management of medicines; Regulation 12 (2) (a) (b) (d) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not always; (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (a) (b) (c)