Accredited Care Limited

Meadows Sands 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Meadows Sands Care Home on 11 January 2017. This was an unannounced inspection. The service provides care and support for up to 26 people. When we undertook our inspection there were 21 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses, or because they were experiencing difficulties coping with everyday tasks, with some living with the effects of dementia.

There was a registered manager 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.

The registered person was not meeting two Regulations under the Health and Social Care Act 2008.There was no maintenance plan or audit for the upkeep of the premises and some areas of the accommodation were not well maintained. Some areas had chipped woodwork, there were unpainted areas and unkempt furnishings. People had been consulted about the development of the home through the use of questionnaires, but these had not been analysed to show what actions may be required to improve the service. Other quality checks, such as care plan and medication reviews had been completed to ensure the home was meeting people's requirements. However, the auditing system was in the early stages of development and analysis of quality checks had improved but required more work to ensure people and staff were aware of what actions had taken place. You can see what action we told the registered person to take in relation to the breaches of the regulations at the end of the full report.

People had a choice of meals, snacks and drinks. Meals could be taken in the dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. However, the menus on display were not in an obvious place and were of small print, so people could not remind themselves of the choices they had made when sitting eating their meals.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there were two people subject to such an authorisation.

We found that people's health care needs were assessed and care was planned and delivered in a consistent way through the use of their care plans. People were involved in the planning of their care. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans were put in place to minimise risk in order to keep people safe. Activities were not

planned into each day, but people told us how staff helped them to spend their time.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period. However, staff also had a list of other work they were asked to complete each day, which they found difficult and look after people.

People were treated with kindness and respect. Staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. On-going training was available for all staff.

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.

Checks were not made to ensure the home was a safe place to live and parts of the premises were unkempt and in need of repair.

Sufficient staff were on duty to meet people's needs. However, other tasks had the potential of impacting on the care delivered to people.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. However, menus were poorly displayed, so people could not be reminded of their choices.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

People's right to privacy was fully promoted and staff showed respect for people in their attitude.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them. The care plans explored the needs of people and how other agencies could help them.

Activities were not planned into each day, but people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

An analysis of audits was not always undertaken to measure the delivery of care, treatment and support given to people against current guidance. There was no record of how actions and improvements to the services were passed on to people and staff including maintenance of the premises.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

There was good team work and staff had been encouraged to speak out if they had any concerns.

Meadows Sands 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 11 January 2017 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to social care professionals before and during the site visit.

During our inspection, we spoke with five people who lived at the service, four relatives, six members of the care staff, two members of the kitchen staff and the registered manager. We also observed how care and support was provided to people.

We looked at four people's care plan records and other records related to the running of and the quality of the service. Records included staff files, minutes of meetings and audit reports the registered manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

We found the provider had failed to maintain the premises in a way that ensured it was safe and secure. This could put people at risk of harm through poor maintenance of the premises.

We were invited into a number of people's bedrooms to see how they had been decorated, which were clean and tidy. However, staff had not taken into consideration when writing the care plans of the environmental risks for some people, especially those with mobility problems or loss of vision. Potentially making this an unsafe environment in which to move around. This did not ensure rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair. The majority of rooms were sparsely furnished with few having photographs, pictures or memorabilia. The registered manager told us this was people's choice, but we could see no evidence in the care plans of whether they had been asked if they would like to personalize their bedrooms. The bed linen was of a poor quality and looked worn and several bed covers had not been ironed giving an unkempt look.

There were numbers on most doors, but we found one without a number on which meant people and visitors were unsure of which room a person was residing in. This had not been corrected since our last visit in February 2016. We saw visitors looking in rooms trying to find the people they were visiting, which meant they had access to rooms and people did not have their own secure private space. There was no other form of pictures or names on rooms which meant people could not recognise them easily. There were signs on the doors indicating what each room was used for, for example, a sitting room or toilet. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be and could go into areas which were not safe for them to enter.

There were areas of the home which needed refurbishment. Woodwork was badly chipped, gouged and marked. Doors were scratched and scuffed. Both of which made it difficult for staff to clean and keep safely maintained. One door was so marked with hand prints we had to ask the registered manager to have this cleaned, which was actioned immediately. In one bedroom a sliding door had been removed in front of the en-suite toilet and washbasin as it posed an infection control risk. However, this had not been replaced and exposed the person to a lack of dignity and privacy when using that area. During our last visit in February 2016 we saw in a corridor area where a door had been removed and the wall plastered ready for painting. This area of wall had still not been painted and exposed the plaster dust. Although some changes had been made such as the replacement of the front door and windows, these areas were not being kept clean. Most outside window ledges were covered in thick layers of bird droppings and most windows and balcony railings were dirty and in need of cleaning. The registered manager told us a window cleaner had recently been found who could reach high windows, but had not commenced the work yet. This posed an infection risk for people, staff and visitors due to coming into contact with unclean surfaces and explosive to bird droppings.

A bathroom on a middle floor had a sign stating not to use, but was not locked. We saw several items stacked in the bathroom such as broken furniture with screws exposed, furniture stacked unsteadily and a

glass vase with stale water in it. This posed a risk to people who may enter as they could easily fall against the furniture or drink the water and cause themselves harm. We were informed this bathroom was due for refurbishment in March 2017. The registered manager stated they would have the lock put on the door the next time the maintenance person was working. The registered manager told us a downstairs shower room was the only bathing facility for the other 19 people to currently use. The skirting boards were badly damaged in the corridors and were in a poorly maintained condition making the area difficult to clean. There was no bath currently available to use. The registered manager told us people were happy to have a shower and showering times were staggered throughout the day to satisfy people's wishes. However, we could not see where this was recorded on the care plans. The poorly maintained environment meant that people were not living in an environment which was a nice place to view and in live in. The unkempt premises could suggest to people that staff were not interested in them enough to maintain a good place to live.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us there were sufficient staff to meet their needs. However, one relative told us, "They always seem very busy." Another person told us, "Yes I think the staff manage the residents safely. I think they have training in it."

Staff were unclear as to their roles within the home as they had to complete tasks, which were not part of their job descriptions. Staff told us that the staffing levels meant they could meet people's needs, but they had other work to do, which caused them a lot of stress. Other work included cleaning communal areas, laundry, cleaning furniture, emptying waste bins and preparing vegetables. The longest list of other work was for the night staff. They told us it was very difficult to fit their other work around looking after people. One staff member said, "I thought I was employed as a carer not a domestic, although a domestic's job is valuable too." Another staff member said, "Staffing is ok. I usually try and fit in my other jobs in the afternoon, which sometimes happens, sometimes not." Another staff member told us, "During the day we can meet people's needs, but it would be easier with someone else due to the domestic work. No one goes without." As the list of work, especially for night staff to complete was so long, this was impacting on the cleanliness of the home as due to some poorly maintained areas they were harder to keep clean. This took staff away for longer than necessary instead of helping people with personal care. We observed that on a couple of occasions staff became focused on other tasks, such as ensuring dining chairs were in the correct position after a training session, rather than talking to people about the forth coming meal.

The registered manager told us they calculated staffing levels on people's needs and daily requirements as recorded in the care plans and each person's individual dependency score. The commissioning team had given them an auditing tool for calculating staffing levels, taking into consideration staff holidays, sickness and training. However, this was not yet in use and the registered manager was anticipating discussing this was the registered person as soon as possible. By not using a verifiable staffing calculation tool the registered manager was unable to calculate whether due to other staff commitments there were sufficient numbers of staff on duty to meet people's needs. There was a contingency plan in place for short term staff absences such as sickness and holidays, which staff members fulfilled using an on call system. We saw the details of this on the staff rota.

We saw that recruitment checks were carried out prior to people being employed at the service. The provider asked for two references, proof of identification and undertook checks with the Disclosure and Barring Service (DBS) to ensure that people did not have any past convictions that would present them as a risk to people living at the service. An interview form was completed and an analysis of prospective staff

capability for posts was made prior to a job offer being made.

People and relatives told us they felt safe living at the home. A relative told us, "I am happy with my family member being here and know they are safe." Relatives told us they felt staff handled their relatives in a safe manner.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis called an event report. However, we saw that an event report had been completed for November 2016 and January 2017 but not for December 2016, but this appeared to be a one off incident. There was no analysis to show themes and trends and how this information was passed to staff. This would help to identify specific safeguarding concerns or improve the practice of staff.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed to see the times when people were prone to fall and how this could be possibly preventable. Permission for the use of bedrails had been sought and were in place so people could be comfortable and not worry about rolling out of bed. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely. This was to ensure each person was capable of being as independent as possible. We observed two staff members transferring a person from a chair to a hoist and then a wheelchair. They did this with dignity and respect, reassuring the person at all times and moved them in an appropriate and safe manner.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would have difficulty managing stairs. A plan identified to staff what they should do if utilities such as gas and electricity failed. Staff were aware of how to access this document. The main entrance to the home was through a reception area where people rang a bell to summon staff to enter. The door was kept locked to ensure that people were safe. However, staff had access to the key and people told us that could use the door when they chose to.

People told us they received their medicines at the same times each day. They understood why they had been prescribed them. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in a locked area, which was very small and difficult for staff to work in, but was clean. Records about people's medicines were accurately completed. However, there was no picture identification of people, which would help when new staff were administering medicines. The registered manager told us that on the last visit by their pharmacy supplier new photographs had been taken, but not received in the home yet. We saw that the last audit by the pharmacy supplier had been in September 2016 and the registered manager would be looking into the delay in photographs being received. Staff told us they had good relationships with the pharmacy supplier and could telephone them about queries. They also supplied

reference material about the medicines in use by people, which we saw in the medicines trolley.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training in the safe practice of administering medicines. Staff did not understand that protocols were required on medicines which had been prescribed to be given when required. This meant they were not recording the criteria for which they were to be used. We saw on the medicine administration records these were very few. The registered manager told us they would ask the pharmacy supplier for assistance to write them correctly and to ensure staff received the necessary training.

Requires Improvement

Is the service effective?

Our findings

People told us they were not aware of the day's menu for the midday meal until it arrived in the dining room and had not had opportunity to discuss their requirements before the meal. Staff told us they always made sufficient so people could choose either of the choices. Menus were not on display in the dining room, but in the main reception area. This was small print and did not take into consideration that some people may not be able to read written English. The registered manager was in the process of completing pictorial menus. We observed staff asking most people what they would like to eat, but did not ask those with memory loss. For those people staff made the choices for them and plates of food were placed in front of them. We saw that staff ensured people were well hydrated during the day. People were offered hot and cold drinks regularly by staff, but staff also made drinks for people when asked to do so.

We observed the lunchtime meal, which most people took in the dining room, but some preferred to eat with tables in front of them in sitting rooms. The tables in the dining room had only been set with cutlery, there were no tablecloths, condiments or flowers. One person asked for some salt which the registered manager gave them. Another person said, "We don't have any napkins either", and those were produced. It was very quiet with little conversation between people and staff until one person asked for some music to be put on a CD player. This was granted and people seemed to liven up in the dining room. We observed three people in a sitting room who had meals placed in front of them by staff. All were living with dementia and appeared not to know what to do with the food, which was starting to become cold. Two were falling asleep and one person was pushing their food around the plate. There were no staff present until we brought this to the staff attention who then attended to people's needs. We were informed staff were on their way to those people, but had become delayed and food was reheated or alternative given.

When people required assistance to eat and drink staff maintained eye contact and coaxed people to eat their meals. Staff wore aprons and gloves to serve meals and ensured those that needed it wore protective cloths over their clothes. One person was struggling to eat their meal and staff were patient with them and later recorded on a chart what the person did eat and drink. We saw in the person's care plan that this was recorded each day. Staff were monitoring the person's weight and liaising with other health professionals on the best approach to ensure the person received a balanced diet to help their health and well-being. We observed staff giving hot and cold drinks throughout the day and there were cold drinks available for people in their bedrooms. Staff told us fresh fruit was purchased for people, but we only saw bananas in the kitchen area on the day of our visit, but fresh vegetables were available along with home baking such as cakes and puddings.

People told us that they liked the food. One person said, "The food is ok." Another person told us, "I have a [named special diet] and they keep me right." Another person said, "I think it's four stars for meals and five stars for staff." People told us they could have breakfast at varying times of the morning. Some told us how they have breakfast early and then went back to bed for a while or back to their room. This was verified by the staff and entries in the daily notes of the care plans.

Staff knew which people were on special diets and those who needed support with eating and drinking.

Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and if they needed assistance. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. There was no record of people's diets in the kitchen area, but kitchen staff told us they knew people's likes and dislikes and would always ask staff if they were unsure.

Staff told us that the induction programme at the beginning of their employment had suited their needs. They told us what the programme had consisted of, which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The registered manager told us that all new staff were now registered for the new Care Certificate. This is a nationally recognised model of training for new staff that is designed to equip them to care for people in the right way by giving initial high quality training. The training records identified which staff had received an internal induction and which were registered for the Care Certificate.

We saw that there was a training system in place commissioned through an external company. This system was flexible and enabled the provider to identify units each year that they felt would be most appropriate to the needs of staff at the time. Staff were expected to work through 'knowledge books' and then their knowledge would be tested and marked by the training company. This would highlight where more training and development would be needed. There was also regular training around issues such as record keeping, health and safety and basic first aid. The training matrix showed that training for most staff was up to date and identified where staff had been asked to complete topics as a matter of urgency and when refresher training was due. Some staff had undertaken training in topics such as dementia awareness, death, dying and bereavement and coping with aggression. Staff told us they enjoyed the training sessions and felt it enhanced their practice. During the course of our visit a practical fire training session took place by an external training company. Staff told us this had been useful, but they hoped never to have to use it.

According to the records all staff had received at least two formal supervision sessions in the past year. This followed the registered person's policy on supervision. For staff who administered medicines a competency observation was completed a couple of times a year. We saw these in the training files. Staff told us the registered manager worked alongside of them and would give instruction when needed. They were then invited to discuss the outcome of any observational supervision to help improve their practice. Those sessions were not written in the training files, which the manager agreed would be good practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. Two applications had been submitted to the local authority and authorised. The documents were within each person's care plan. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. Staff gave us a good explanation of what the MCA and DoLS would mean for the people they looked after.

Staff told us that appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held after assessments had been completed to test their mental capacity and ability.

Some people had made legal arrangements for a relative or other representative to make decisions on their behalf if they were no longer able to do so for themselves. We saw those arrangements were clearly documented and were correctly understood by the registered manager. This ensured suitable steps could be taken to liaise with relatives and people's representatives who had the legal right to manage people's affairs.

We heard staff speaking with relatives about hospital appointments after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. People told us they had appropriate and timely access to health care. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people required the help of an occupational therapist and a nurse from the community mental health team. Staff had recorded when people had seen the optician and chiropodist. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits.

Relatives told us they had confidence in the staff to look after their family members. One relative told us, "They keep me well informed and always ring if there is anything amiss." Health and social care professionals told us staff liaised with them. Two professionals told us how a person had improved since being in the home.

Good

Is the service caring?

Our findings

We observed that staff were kind and caring when addressing people's needs. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone wanted to use the toilet. Staff stopped what they were doing and ensured they quickly took the person to a toilet. People and relatives told us they liked the staff and felt well cared for by them. One person said, "They are lovely this group of staff." A relative told us, "I think they all do a good job here.They are always busy when you come and visit and they are polite and all that."

People were given choices throughout the day if they wanted to remain in their bedrooms or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There was also a quiet place in the reception area where people could sit. We observed people in that area, some with other people and some with staff. People told us they liked to sit there as they could see who was coming and going and liked to speak with visitors, which we observed.

Some people either through choice or because they were ill choose to be in bed. We observed staff attending to people's needs. They ensured they answered people's call bells promptly and politely asked what they required before fulfilling the person's wishes. Where people required to have their bedroom door open a screen had been placed on one side of their bed. This enabled people to remain in bed, but look out of the window and at the rest of their bedroom. They were then not seen by passers-by. One person did not have a call bell which worked so we brought this to the staff attention and it was rectified immediately. We later tested that call bell, with the person's permission, and staff arrived promptly. One person said, "If I press my buzzer they come."

The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. An example of this was with people who had problems hearing. Staff ensured the batteries in people's hearing aids were working and when speaking to people staff spoke clearly, ensuring each person had understood what they had said. They also gave people the time to express their wishes and respected the decisions they made. For example, people whose speech had been affected by their illness. Staff gave them time to say what they needed to and kindly asked for clarification if required. Some people used hand and head to communicate, such as a thumbs up movement and a nod or smile, which staff understood.

People appeared well dressed. Several ladies had jewellery and makeup on and the gentlemen were groomed and well presented. One person was having a manicure whilst staff chatted animatedly too them about their life in the town. We saw that if people wished to go out they were dressed appropriately for the cold weather.

Relatives told us how staff had supported them when their family members were very ill. They told us staff had been very comforting to them as well as their family members. They had been kept informed about events and felt included in discussions. Staff were described as kind and treated people with dignity. One

relative said, "My [named relative] is happy here so that's all that matters."

We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them. Staff were able to take a telephone to people so they could have a private conversation if they desired.

People told us staff treated them with dignity and respect at all times. They told us staff ensured they knocked before entering their bedroom, ensured doors were closed correctly when they used a toilet and closed curtains when they were attending to their hygiene needs. We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment.

In the care plans there was clear information on plans for people's health and well-being over a period of time. For example, where people had physical needs, such as mobility problems. In one care plan we saw a person had mobility problems and required the use of a wheel-chair. Staff had ensured this was the correct fit for them and recorded any on-going maintenance to ensure the wheel- chair was safe to use.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our visit

Good

Is the service responsive?

Our findings

Prior to admission each person was assessed to see if the home could meet their needs. The initial assessment was stored in people's care plans. This included details of each person's past medical history and what risks had led to people requiring admission to the care home. As staff became more familiar with people's needs and wishes there was then opportunity for a full plan of care to be produced. A relative told us how involved they were with the planning of care with their family member and staff.

Where there had been incidents where people's behaviour could be harmful to themselves or others, staff had analysed the causes of people's behaviour. For example, when a person refused care such as moving about to prevent pressure damage. Consideration had been given to whether the person required an increase of observation or whether this had been discussed with the local authority safeguarding team and commissioners of the services being provided. This meant staff had some means of knowing the triggers which could result in a person's behaviour and would therefore help to prevent them and others being harmed.

The wording in the care plans showed the care plans were written with people, as opposed to them and their views were being recorded. Staff told us care plans were to be updated every month and this was in the care plans. We saw that paper records which contained private information were stored securely. In addition, electronic records were held securely in the home's computer system. This system was password protected and so could only be accessed by authorised staff. We found that staff understood the importance of respecting confidential information.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use, which staff told us helped them see quickly any work which was required to be finished.

People told us that staff would contact other health and social care professionals if they needed them. There was evidence in the care plans that staff had arranged visits and sought advice from a number of health and social care professionals, as well as family and friends. There was evidence of joint agency working to ensure people could access all the resources they required. This could result in people receiving the appropriate care to meet their needs.

We were informed by the registered manager that the activity co-ordinator post had just become vacant and staff were trying to ensure that each day people could have a choice of social activities. Staff told us activities were arranged through consultation meetings with people and there was evidence in the care plans that people had been asked what they enjoyed doing and if they had a specific religious or cultural needs. A set programme was not currently available, but staff recorded events in the daily notes of the care plans what people had taken part in. There were photographs on display of events which had taken place such as entertainers, parties, baking and movement to music sessions. However, the photographs had not been dated so we did not know when the events had taken place. People were watching the news on the

television and there were magazines and books, some in large print, available.

People told us there was currently little taking place regarding social activities. One person said, "We don't have lots of things going on. We used to do things like painting and that, but we don't do it anymore." Links with the local community were made when people expressed what they wanted to do. For example, attending a local church service or visiting the shops. Although people told us those events usually took place with the help of their families and friends. One person responded to our question about visiting the local area and said, "We don't go out unless a relative takes us." This was confirmed by staff who told us it was difficult at the moment to take people out as the weather had been poor and the activities person used to take people out. Each care plan had a document which was entitled, "This is your life." This gave details of people's past lives, their interests and hobbies. Staff told us these were works in progress as they learnt about people and their lives. People told us they did not have to complete them, but most were delighted to talk to staff about their lives. Most had been completely finished.

The provider had a system for managing complaints and this was available in the reception area of the home for people to access. However, this did not give any details of who to contact outside the home if people were not satisfied with the outcome of a complaint. We reviewed the complaints information and there was a record of formal complaints which had been dealt with by the registered manager. The complaints had been dealt with appropriately. There was no record kept in a central place of informal complaints or discussions about people's care that the provider could use to track trends and learning from. We did see in the care plans when meetings had taken place with people, their relatives or representatives if concerns had been raised and how these had been addressed.

Requires Improvement

Is the service well-led?

Our findings

Some systems for auditing and monitoring the service were in place but these were in the early stages of development. The infection control audit was overdue as the last one was completed in November 2015 and it was to be completed yearly. Therefore the registered manager had no way of telling whether infection control protocols were being followed by staff to ensure people were free of risk. There was no maintenance schedule or list of work which needed to be completed and as detailed in another part of this report the standards of maintenance within the premises was poor. For example, we saw a fire door propped open as the closure mechanism was faulty. The last maintenance and grounds audit had been completed in August 2016, which still had work outstanding to be completed.

There had been a care file audit in September 2016. This was an overview document about what should be present in each care plan file. The audits that had been completed did identify areas for improvement, but there was no record of how information had been passed on to staff to action. For example, whether people's end of life wishes were recorded.

The registered manager told us they did not hold meetings with people as few attended and showed us a meeting request, which stated there was no attendance by people who lived in the home. The registered manager had no effective systems to gather and record the views of people. There was no system for recording whether suggestions had been implemented from informal discussions with people. This meant the registered person could not demonstrate how effective those meetings were in influencing developments in the service. There were however some feedback forms in a file, which the registered manager told us had been returned through 2016 on topics such as care plans and menus. There had been no analysis of those forms to see if trends and themes were emerging.

There had been four staff meetings in 2016. The registered manager told us this was because of so many staff changes that they preferred to talk with individual staff members to discuss issues. We saw the minutes of a staff meeting for December 2016 when amongst other topics laundry, the environment and care plans had been discussed. Staff told us they could voice an opinion at staff meetings and felt their opinions were valued, but they saw little change, especially in the environment.

Shortfalls in assessing and monitoring the quality of the service had reduced the registered person's ability to protect and promote the health, safety and welfare of people who lived in the home. There were no records to show the registered person had checked the quality of the services being provided and whether staff were upholding the principles of the home as explained in the statement of purpose.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We found that the website for the home was out of date. It referred to information dating back to 2014 and did not fully reflect the current level of services being provided within the home. This could mislead people into how the home could meet their needs.

There was a registered manager in post. They appeared to know each person very well and could recall small details about each person's life. People and relatives told us they could express their views to the registered manager and felt their opinions were valued. One person said, "I think the manager is a nice lady. I have nothing to complain about." A relative told us, "I think this is a well led home." People and relatives told us the manager was a hands on manager and interacted with people each day. People appeared to know her and welcomed her all the time with a smile and cheery hello.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was no maintenance plan or schedule in place to ensure the premises were in a fit state of repair for people to live in and would not put people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Shortfalls in assessing and monitoring the quality of the service had reduced the registered persons' ability to protect and promote the health, safety and welfare of people who lived in the service.