Eckling Grange Limited

Eckling Grange

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?	**Good**

Summary of findings

Overall summary

This inspection took place on 28 and 29 July 2016 and was unannounced. Eckling Grange is a care home providing personal care for up to 60 people, some who live with dementia. On the day of our visit 54 people were living at the service.

The home has had the current registered manager in post since before June 2013. 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.

At the last inspection on 30 January and 2 February 2015, we asked the provider to take action to make improvements to medicines management, systems to assess and monitor the service, and to notifications sent to us. We received an action plan advising that the provider was going to address these issues by 29 May 2015. We found at this visit that this action had been completed.

Although medicines were securely stored, temperature checks of storage areas had not been accurately recorded, which put the effectiveness of medicines at risk. Medicines were safely administered, and staff members who administered medicines had been trained to do so. The provider monitored care and other records to assess the risks to people and ensure that these were reduced as much as possible and to improve the quality of the care provided. We have received notifications of important events, as required by law.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff members understood the MCA but did not presume people had the capacity to make all decisions first. Records were not available to show people's capacity to make decisions about their medicines had been assessed before giving them medicines covertly when they did not want to take them.

The service was meeting the requirements of DoLS. The registered manager had acted on the requirements of the safeguards to ensure that people were protected. For decisions other than administration of medicines, mental capacity assessments were completed. Where someone lacked capacity, best interest decisions had been made.

Staff were aware of safeguarding people from the risk of abuse and they knew how to report concerns to the relevant agencies. Staff assessed most individual risks to people and reduced or removed. Personal evacuation plans were not available, although staff members knew how to safely evacuate people. There was adequate servicing and maintenance checks to fire equipment and systems in the home to ensure people's safety.

People felt safe living at the home and staff supported them in a way that they preferred. There were usually enough staff available to meet people's needs and action was taken to recruit more staff. However, some people still had to wait at times. Most recruitment checks for new staff members had been obtained before new staff members started work but action was needed to obtain all the required information.

Staff members received other training, which provided them with the skills and knowledge to carry out their roles. Staff received adequate support from the registered manager and senior staff, which they found helpful.

People enjoyed their meals and were able to choose what they ate and drank. Guidance for staff about how much people should drink each day was not always available and staff did not always spend enough time helping people to drink. Staff members worked together with health professionals in the community to ensure suitable health provision was in place for people.

Staff were caring, kind, respectful and courteous. Staff members knew people well, what they liked and how they wanted to be treated. People's needs were responded to well and support was available. Most care plans contained information to support individual people with their needs. They did not always provide staff with enough guidance about managing people's diabetes. People's relatives said that people were happy at the home and that they were able to be as independent as possible.

A complaints procedure was available and people were happy that they did not need to make a complaint. The manager was supportive and approachable, and people or other staff members could speak with her at any time.

Staff worked well together in their own areas of the home. However, a few staff did not feel consulted about working arrangements or that their concerns were listened to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were usually enough staff and there were times when people were kept waiting. Most checks for new staff members were obtained before they started work.

Risks had been assessed and acted on to protect people from harm, people felt safe and staff knew what actions to take if they had concerns.

Medicines were safely administered to people when they needed them but the storage temperatures were not accurately recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff members received enough training to provide people with the care they required.

The registered manager had acted on guidance of the Deprivation of Liberty Safeguards and staff had access to mental capacity assessments and best interests decisions for people who could not make decisions for themselves. However, capacity assessments for people who did not want their medicines were not completed before medicines were given covertly.

Staff worked with health care professionals to ensure people's health care needs were met.

People were given a choice about what they ate and drank. Guidance for staff about how much people should drink was not available and staff did not always spend enough time helping people to drink.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people living

at the home. Most people received the care they needed, although some people had to wait and sometimes they did not have support to drink enough.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff members planned for people's individual needs and they responded quickly when people's needs changed. However, there was not always enough information about people's individual needs for diabetes.

People were given information if they wished to complain and there were procedures to investigate and respond to these.

People enjoyed a variety of activities, including a range of spiritual and religious services.

Is the service well-led?

Good

The service was well led.

Audits to monitor the quality of the service provided were completed and identified the areas that required improvement. Actions had been taken that addressed any issues raised from the completion of the audits.

There was a positive culture within the home.

Eckling Grange

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 28 and 29 July 2016 and was unannounced. This inspection was undertaken by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed this and other information available to us about the home, such as the notifications they had sent us. A notification is information about important events, which the provider is required to send us by law.

We spoke with six people using the service and with four people's relatives. We also spoke with the registered manager, the deputy manager, 17 care workers and a health care professional visiting at the time of our inspection.

We spent time observing the interaction between staff and people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records for seven people, and we also looked at the medicine management process and records maintained by the home about staff training and monitoring the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2015 we found that not all people received their medicines as they were prescribed and that some people were given medicines covertly without this being discussed with health care professionals. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider wrote to us in May 2015 about how they were going to improve in these areas. They told us that they would audit medicine records each month and they would review medicine administration policies for both general administration and covert administration. They also told us that they would provide additional training to staff as necessary.

We found during this inspection that there had been improvements in these areas but that there were concerns about the recording of temperatures in medicine storage rooms. In one part of the home we found that storage temperatures had not been recorded every day and that the thermometer recording these temperatures was situated outside the storage room. In the other part of the home we found that storage temperatures had been recorded every day. However, these were recorded frequently at temperatures over manufacturers' guidelines.

We noted during our visit that the medicines storage room was warm but not as hot as the temperature records indicated. We looked at the thermometer and found that the temperature was within an acceptable range for safely storing medicines. The registered manager advised following our visit that staff members had been incorrectly reading the thermometer and that they had installed a new device that was easier to read.

People told us that they received the medicines as they had been prescribed. The records kept regarding the administration of medicines were in good order. They provided an account of medicines used and demonstrated that people were given their medicines as intended by the person who had prescribed them. We found that where medicines had not been given, there were codes to show the reason for this.

Information was available to guide staff where people received their medicines covertly. This included the safe preparation of medicines given in a different way, such as when they were crushed. Medicines were stored safely and securely in a locked room for the safety of the people who lived in the home.

At our previous inspection we found that there were areas within the home that posed potential risks to people's safety and auditing processes had not identified these issues. We referred our concerns to the Infection Prevention and Control team (IPCT). Prior to this visit we received information from the IPCT to show that the provider took immediate and comprehensive action to address areas of concern identified at our previous inspection. At this visit we found that all areas in both parts of the home were clean and tidy. We looked at four bathrooms and found that these were clean, toilet equipment was clean and there were no offensive smells.

Risks to people's safety had been assessed and recorded. These were individual to each person and covered areas such as, moving and handling, people's risk of developing pressure ulcers or from falling. Each

assessment had clear guidance for staff to follow to reduce the risk so that people remained as safe as possible. Our conversations with staff demonstrated that they were aware of these assessments and they followed the guidance. Although staff updated most assessments when changes had occurred, we found that they had not reassessed one person's risk of falling following an incident.

Staff members told us how they would evacuate people and showed that they had an appropriate understanding of how to safely carry this out. They also explained and gave us examples about people who would need additional assistance in this situation and how they would assist them. However, personal emergency evacuation plans (PEEPs) were not available to guide staff or emergency services in the event of an emergency. We spoke with the registered manager who told us that they would complete PEEPs to make sure that each person's individual risk was assessed.

Servicing and maintenance checks for equipment and systems around the home were carried out. The registered manager confirmed that systems, such as for fire safety, were regularly checked and we saw records to support that these were completed. We saw that fire safety equipment had received a maintenance check in the six months prior to our visit. We concluded that individual and environmental risks had been appropriately assessed and reduced as much as possible, although not all of these were recorded.

People told us that they felt safe living at the home and that they could talk to someone if they had any concerns.

The registered manager had taken appropriate steps to reduce the risk of people experiencing harm. The staff members we spoke with understood what abuse was and how they should report any concerns that they had. There was a clear reporting structure with the registered manager responsible for safeguarding referrals, which the other staff members were aware of. They told us that they would also report concerns immediately to the local authority safeguarding team or other agencies, such as the Care Quality Commission (CQC), if needed. These contact details were available in the office for everyone at the home to see. Staff members had received training in safeguarding people and records we examined confirmed this. A whistle blowing policy was also available and information about this was posted on a notice board in the home.

The provider had reported safeguarding incidents to the relevant authorities including us, CQC, as was required. This meant we were confident that staff recognised and reported any safeguarding concerns correctly.

Three of the five people we spoke with told us that they did not think there were enough staff. They said that this led to a delay in having call bells answered and that this was particularly noticeable in the evening when people went to bed. Staff members told us that they thought there were enough staff and that this was due to recent recruitment. However, they did acknowledge that prior to this there had been times when people had had to wait for help.

We observed that staff members were always available in the communal areas of the home and that they organised where they worked to make sure of this. Call bells did not ring for long periods during our visit and staff members worked at a calm, unhurried pace. We looked at the call bell activity for the two weeks before our visit. Staff had responded to most call bells within five minutes, although we saw one day when a third of call bells were not responded to within ten minutes. There were also times when people waited up to 20 minutes and occasionally up to 45 minutes for their call bell to be answered.

The registered manager confirmed that they used a staffing tool to determine the number of staff required based on people's care needs. They worked on a ratio of one staff member to four people living at the home. The registered manager told us there were 54 people living at the home with 17 staff members on a morning shift and 13 care staff on an evening shift. This provided ratios of approximately one staff member to every four people during the day. We have concluded that there were enough staff available to meet the needs of people living at the home. However, staff did not always either respond to call bells quickly or they did not deactivate the alarm when they did respond.

We checked three staff files and found that most of the recruitment checks and information, such as Disclosure and Barring Service (DBS) checks, was available. These had been obtained before the staff members had started work. The provider had asked for information about staff members' previous care employment and the reasons that they had left the position before the staff member had started work. However, we saw that in two of the three staff files, there were no explanations for gaps in employment histories. This meant that although the provider obtained most information to show a prospective staff member was safe to work with people, they needed to take further action to ensure that all the required details were available.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in January 2015 we found that for people who received their medicines covertly, staff had not assessed whether they had capacity to make decisions or not. At this visit we found again that staff did not complete mental capacity assessments for two of the three people whose records showed they received medicines covertly. The provider's guidance, which was included in people's records, stated that staff had to complete a mental capacity assessment before they gave medicines covertly. This meant that staff had not undertaken a formal process to determine whether these two people were able to make their own decisions about taking their medicines.

However, staff members completed a 'pros and cons' sheet to determine the risks associated with giving the medicines covertly against not giving the medicines. Their records showed that a health care professional had been involved in the decision to give medicines covertly. We saw no information within this 'pros and cons' record to show that other people, such as family members, had also been consulted. Following our inspection the registered manager confirmed that staff consulted family members and their views had been recorded in another part of the care records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found that this was happening in practice, although not all records had been completed. Staff members were clear about what the MCA meant and their role in ensuring people were able to continue making their own decisions as much as possible. We saw that staff members had received training in this area. We saw evidence that staff applied these principles during our visit. For example, staff supported people to make decisions about the care they received, activities they took part in and what they did during each day.

People told us that staff asked their consent before carrying out care tasks and respected their decisions. We saw that staff asked for people's consent before delivering care. They understood the importance of supporting people to make their own decisions, for example, by offering people choices if making decisions was difficult for them.

At our previous inspection we found that staff completed mental capacity assessments, although the records for these did not show how a lack of capacity had been decided. They did not include what actions they had taken to determine whether a person understood, or could remember the possible consequences of a decision. At this visit we saw that staff continued to complete mental capacity assessments for most decisions, except for medicines administration, that people had difficulty making. These records contained

details about how the decision had been determined and the process staff members had gone through to assess this. Best interests decisions had been completed and information about how best to support people had been written into care plans. We saw that these records were clear in regard to how staff members were to support people in continuing to make their own decisions where possible.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to lawfully deprive a person of their liberty. The registered manager submitted applications to the local authority for people living at the home who would not be able to leave or who required constant supervision. They were aware of DoLS and the actions they needed to take if they had to deprive someone of their liberty in their best interests.

People told us that they liked the food that they were given, how it was presented and that they could usually choose what they ate. One person said, "I have no complaints about the food. We have fresh fruit and vegetables." Another person commented, "I like the variety and presentation of the food, it's very good. There's more than enough to eat."

People had enough to eat to meet their nutritional needs and staff members told us that people had a choice each day. People in both areas of the home were able to choose their meal in the morning. However, staff in one area of the home did not always remind people of their decision or give them the option to change their minds. One person told us that they had not been offered a choice. We saw that they had not eaten all of their meal but staff did not offer an alternative.

We saw that the lunch meal was a social affair, with conversation around each table and staff that were available during the mealtime. Staff members helped people to eat if they needed this and made sure they spent time encouraging the person with their meal. This promoted people's experience of mealtimes as positive and staff were available to assist them if needed.

We saw that people had a choice of drinks during the mealtime and there were condiments on each table for them to use. People were able to eat at their own pace and they could choose where to eat their meal, whether that was in the dining room or in their own room. We also saw that hot and cold drinks were available throughout the day in communal areas and a staff member went round to people's rooms frequently with hot drinks. Fluid records in one area of the home showed that people were encouraged to drink enough to keep them hydrated.

In the other area of the home, staff members did not always spend enough time helping people to drink. We observed on two occasions that staff members either did not spend very long with people or did not return to give them drinks. Fluid records in this area also showed that people often drank less than a litre each day. One person who was assessed as being at risk of not drinking enough did not have their drinks monitored at all. We spoke with a senior staff member who confirmed that there was no guidance for staff to determine how much each person should drink each day.

Records showed that people's weight was recorded and this enabled staff to take the necessary action if there were any concerns about unintended weight loss. We looked at care records for three people with nutritional assessments. These showed us that assessments to determine the risk to each person from not eating enough had been completed accurately. Staff took appropriate actions, such as providing soft or puree meals, fortified meals and referral to an appropriate health care professional.

People told us that they thought staff received enough training to be able to meet their care needs. One person commented, "Oh yes, they know me well and they're trained okay." Staff members told us that they

received enough training to meet the needs of the people who lived at the service. They said that they had completed a mixture of practical hands on and theory training from the registered manager and external trainers. They received annual updates to training that they had already received and they were able to complete national qualifications. One staff member said that they had used the results of their national qualification to start other training that would lead to a future career in health care.

We checked staff members' training records and saw that they had received training in a variety of different subjects including, food hygiene, eating and drinking, and safeguarding adults. Staff also completed training in other areas affecting people living at the home, such as palliative care and bereavement.

Staff members told us that they had regular supervision meetings with the registered manager and felt well supported to carry out their job. They told us that the support came in different forms, such as formal meetings, where their performance was discussed, and team meetings, in which they could raise any issues they had. Records were kept of these discussions and the staff members were able to see these whenever they wanted.

There was information within people's care records about their individual health needs and what staff needed to do to support people to maintain good health. We found evidence that people saw specialist healthcare professionals when they needed to. For example, staff referred people to a speech and language therapist and a dietician when they had been concerned about their weight loss. Advice from the specialist had then been implemented to reduce the risk of further incidents. Other people's records showed that they had their care needs reviewed by a range of health care professionals, including the local GP, dentist, and optician.

Good

Is the service caring?

Our findings

At our last inspection in January and February 2015 we found that people did not feel that staff members were particularly friendly or caring. At this visit we found that people's views had changed. People told us they were happy living at Eckling Grange and that staff were kind and caring. One person told us, "Friendly and loving with a Christian influence. I was so ill when I came here and through their loving care they got me better." Everyone else we spoke with said that staff were all caring and kind.

Visitors to the home echoed people's views of staff members and that they were gentle and comforting. One visitor commented that, "Staff are very kind, they are brilliant. I cannot speak highly enough of them."

During our visit we found that staff were kind and considerate towards people, and developed caring relationships with them. We heard and observed laughter when people joked and talked with each other and with staff members. They were relaxed with the staff who were supporting them and the interactions we saw were positive. Staff engaged in meaningful conversations with people and we saw that they were treated as individuals. We observed one staff member discuss with two people who had been spending time in a quiet lounge what they would like to do in the afternoon. The staff member knew what each person would usually do and asked if they wanted to do that or something else, and then provided other suggestions. They spoke gently with both people and let them know exactly what they were going to do to enable the person to take part in their chosen activity.

We also found at our previous inspection that not all people were treated with dignity when staff members spoke with them. At this visit we saw that staff were polite and respectful when they talked to people. They made eye contact with people and we observed staff communicating with people well. They were patient with people who found it difficult to verbally communicate and consequently understood their requests. We saw one staff member spending time with a person who was very unwell. The staff member stayed with the person and read to them, which provided comfort and reassurance.

Staff involved people in their care and listened to their responses. One person told us, "You are treated as family from the top to the bottom of the home. The staff do listen and I absolutely can talk to them if needed." Another said, "Yes they [staff] do listen and I do talk to them – they [staff] are very understanding." One visitor told us that they were involved in planning their relative's care when that person was not able to do so. They said that staff always respected their opinion as they knew the person's wishes.

We saw that staff asked people what they would like to do and offered them options to help them decide. For example, we saw that staff members asked people whether they wanted to come to the dining room for the midday meal or to eat in other areas of the home. Once in the dining room we saw staff members discuss with people where they wanted to sit. People were given choices about what to eat, drink and where to spend their time within the home. We saw that people were able to complete personal care tasks when they wanted to throughout the day and this was not limited to a particular time. From our observations it was clear that staff consulted people about their care.

People told us that they were able to make decisions about and plan their care. They said that they often had family members with them when this happened on a formal basis. Visitors told us that whether they were involved in planning their relative's care or not, staff always included the person living in the home.

Care records provided staff members with guidance about how able people were and we saw that people were encouraged to continue as much as possible for themselves. There was information in relation to the person's individual life history, likes, dislikes and preferences written within the person's care records. Staff members told us that this helped them to strike up conversations with people. We saw that care records contained details of who had been involved in planning and reviews of the person's care.

We asked people if staff respected their right to privacy. One person told us that, "The staff show respect and kindness. I'm quite independent and the staff encourage me to remain so. They are respectful of my privacy and never walk into my room without knocking." Visitors also agreed that staff members respected people's privacy. One visitor said, "They [staff] … are always respectful. The care is excellent."

We saw that staff respected people's dignity and privacy. They were seen quietly asking people whether they were comfortable, needed a drink or required personal care. Throughout the day we saw that staff members knocked on people's doors before entering their room, they spoke with people in a respectful way and called people by their name. In communal areas of the home we saw that staff used screens to protect people's privacy when they used mechanical equipment to support people to move around. We saw that the registered manager spoke with people often to discuss how their day had gone and to talk about any difficulties they had. Care records indicated where people had contact with their families and information was recorded when staff members had involved family members in people's care.

Good

Is the service responsive?

Our findings

At our last inspection in January and February 2015 we found that staff did not always complete actions, such as weighing people as often as was required. During this visit we found that care plans were in place and gave staff guidance required to support people with their identified needs. In addition to guidance about how to meet people's physical care needs, care plans also provided information about people's spiritual and advanced planning care needs. Staff members told us that care plans were a resource in terms of giving information to help provide care and that all staff members helped to record details about people's daily lives. We found that staff members followed the guidance and that information was updated when people's care needs changed.

However, we also found that in regard to caring for people with diabetes, there was not always sufficient information about the person's individual needs in relation to the condition. For example, there were no details about the effect diabetes had on the person and what staff members should do in specific circumstances. There was a risk, therefore, that staff members may not know what to do or how to recognise if a person's blood sugar level was too high or too low. Care records showed that staff members monitored people's blood sugar levels and that these were stable. We spoke with the registered manager who told us that they would update these care records.

We saw during our visit that some people who lived in the home displayed behaviour that might challenge or upset others. We looked at the care records for these people and saw that the information was a good reflection of the each person's current mental health needs and they provided enough guidance about the action staff should take. We spoke specifically with one staff member about one person's needs and found that the staff member knew the person well. They knew what actions to take if the person became distressed and they were able to describe the person's character in detail.

People told us that they were cared for as they wished. One person said, "I get up and go to bed when I choose and spend my time as I please through the day." Two other people echoed this person's comments by telling us that they were able to carry on their own schedules. One person told us, "You are not forced to do anything so I have my own little routine. The staff help me as much as I need them to." However, three people also told us that there was a delay, noticeably in the evenings, when staff responded to call bells.

We observed that staff were responsive to people's needs. They encouraged people to drink when they indicated that they were thirsty, to eat when they were hungry and to attend to personal care if this was required. One person told staff that they were cold and a staff member immediately brought them a blanket. There had been a recent increase in staffing numbers and we saw that staff worked at an unhurried pace on the days of our visit. Despite this increase in staffing numbers, we saw from call bell records that people still had to wait for help and support, sometimes for over ten minutes and occasionally up to 45 minutes.

We examined records that were kept of the care that had been given to people, such as those recording when people had been supported to change their position if they were cared for in bed. These showed that staff members gave people care as often as was required to maintain the person's health and well-being.

Care records were written in a way that promoted people's wishes and preferences, although these were written in more detail in one part of the home than the other. They included details about people's preferences, such as particular food likes and dislikes, and hobbies and interests people had. However, not all plans included information about when people liked to get up or their preferences for a bath or shower. Staff members were able to tell us in detail about the people living in the part of the home that they usually worked in. However, they did not know all of this information when they went to work in the other part of the home, which meant that if there were unexpected staff shortages, people may not have their care needs met in the way they preferred.

People told us about the activities, events and entertainment that was available for them to take part in. One person told us, "There is normally a jigsaw in this lounge, I like that very much, like adding pieces. I join the prayer groups and [activities coordinator] activities. She's very good." Other people also commented on the communal jigsaw that people were able to work on when they wanted. Visitors to the home were similarly complimentary about how people were able to spend their day. One visitor told us, "There's lots going on and the activities woman seems very highly thought of. [Relative] goes to lots of things."

We talked with a member of staff who confirmed that there were activities coordinators in both areas of the home. They provided different activities to meet the individual needs of people in the two areas. We saw in the area where people were less able to verbally communicate, that the activities coordinator sang and read to them. People clearly enjoyed this interaction and we observed that one person, who had previously been withdrawn, listened attentively to the story. People had their own plots in the garden where they grew flowers and vegetables, which were then used in the kitchen. A member of staff maintained the garden and helped to support people.

We saw that there were organised activities and things for people to do each day. Staff encouraged people to participate and information about what was available was posted on a notice boards. Religious services were available frequently and people we spoke with told us they valued these times. One person told us, "The spiritual life here is very important. I go to the spiritual groups, the Wednesday Women's Service and the Sunday Service, as well as the prayer groups." Another person said, "I feel very much part of the Christian fellowship here."

People told us that they went out to the local town centre, to visit church on Sunday with relatives and we saw that there had been a recent trip to the coast. They were able to keep in touch with relatives and friends, and staff members helped them to do this. One person told us that they had their own phone to do this, while other people said that staff helped them to use a communal phone. Another person said they were able to keep in touch with people by email.

People and visitors told us they would be able to speak with someone if they were not happy with something. They gave us a variety of people who they would talk to, from care staff to the registered manager. They all felt that their concerns would be properly dealt with, although no-one had needed to make a complaint.

Staff members told us that information was available for people if they wanted to make a complaint. A copy of the home's complaint procedure was available and provided appropriate guidance for people if they wanted to make a complaint. There were details about other organisations to contact if a complaint had not been resolved. The registered manager told us that no complaints had been made in the last 12 months.

Good

Is the service well-led?

Our findings

At our previous inspection in January and February 2015 we found that the provider had not always sent us notifications of important events affecting people living at the home. This was a breach of Regulation 18 of the CQC (Registration) Regulations 2009. The provider wrote and told us that they would make sure all staff members were aware of the need to promptly report incidents to the management team so that they could submit notifications. We found at this visit that the registered manager and provider reported incidents to us as required.

At our previous inspection we also found that quality assurance systems were not effective assessing and monitoring the quality and safety of the service that people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider wrote and told us that they would review and develop a more robust auditing system by 29 May 2015.

At this visit we found that the registered manager completed audits, such as for the domestic environment, cleaning, hand hygiene, which fed into the organisation's quality monitoring report. Audits identified issues and contained clear information to show the actions that had been taken to address them. For example, we found that care plan audits identified where records had not been completed. The registered manager and senior care staff took action to address this and reflected this in the next care plan audit, with action also taken to address on-going issues with individual staff members. We saw that where issues had been identified, information was also available to show how these had been rectified. Although these audits included a qualitative aspect they had not identified that there was variable information in care plans in regard to preferences and diabetes care. The registered manager told us that they would amend these records.

Analysis of accident and incident records had been carried out and looked at the type of accident or incident that had occurred. This information was then logged for each person. However, the analysis did not look at any other trends or themes, such as time or location of all falls. Although statistical information was discussed in the provider's Health and Safety meeting, information about trends and themes over a period of time was not available. Information was available in the analysis to show actions that had been taken to address each incident and to reduce the risk of it occurring again.

We found that the provider's system for assessing and monitoring the home provided enough information to do this, although further review was needed to show emerging trends.

People we spoke with liked living at the home and said that they would, and in one person's case, had recommended it to others looking for a care home. One person told us this was because they enjoyed the spiritual activities that were available. A visitor told us that they thought there was an open culture in the home, and they could talk to staff or the registered manager at any time.

People told us that there were meetings where they could share their views of the home. Two people told us that they attended meetings and had raised concerns in this way, although they also said that no action had

been taken about these issues. We saw from the last meeting minutes in April 2016 that there had been a response to one of the issues that had been raised. The registered manager confirmed that the request for alternative facilities to a bath had been raised with the trustees. This had taken time to consider due to the renovation works that would be required and the trustees were still considering the request.

We asked if people and their relatives were given the opportunity to give their views of the home in any other way, such as through a questionnaire or survey. They told us that they did not remember being asked to complete any of these. The registered manager told us that the last survey had been completed in November 2014. Responses had been collated and an action plan had been developed. The next survey was due in November 2016.

Staff members told us that they worked well together within their own areas of the home and that staff morale was good, but some staff said that they found it difficult to work in other areas. The registered manager told us that they had addressed a reluctance for staff members to work together by asking staff to work in different parts of the home. However, some staff had not felt listened to or consulted when they had raised concerns about this new way of working.

Three staff members told us that they would like more team meetings in which to discuss issues. They were unable to recall when the most recent meeting had taken place, while other staff thought these occurred every six months. Staff communication meeting minutes showed that there had been a meeting in August 2015 and in January 2016. The minutes recorded information but did not show any discussion, views, opinions or concerns from staff members.

We concluded that there was a positive culture in the home. An open culture could be improved by better communication in regard to the reasons for change or delays in requests for change.

People told us that they knew who the registered manager and other members of the senior management team were. They said they were all approachable and were often available around the home. We observed that the registered manager was visible around the home throughout both days of our visit. The home has had the current registered manager in post since before June 2013. The registered manager confirmed that they had support from the provider's general manager and trustees, who were available at any time if the need arose.