Roberttown Care Home Limited

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 and 21 December 2015 and was unannounced. We had previously inspected the service on 26 February 2015 and at this inspection the service had breached the legal requirements relating to safe care and treatment, staffing levels, consent, person centred care, good governance and safeguarding. We found significant improvements had been made at Roberttown since our last inspections and they were meeting the regulations apart from the management of medicines.

Roberttown Care Home provides personal care and nursing care for up to 29 people. At the time of our inspection there were 24 people living at the service. The home provides accommodation over three floors with lift access between floors. There is a garden area to the rear and parking to the front of the home.

At the time of our inspection the manager was awaiting registration with the Care Quality Commission. 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.'

We found medicines were stored appropriately and medicines in the monitored dosage system were administered appropriately. However, we found boxed medicines had not been administered safely and the system for auditing and signing for medicines was not robust as errors had not been picked up. This was a breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents

We found risk assessments in the care files we reviewed for choking, medication administration, moving and handling, falls, pressure ulcers and for the use of the bath hoist which demonstrated the home had a system in place for assessing and managing risk to the people living there.

We were told by staff and people using the service there were enough staff to meet their needs. However, we observed at busy times such as when medicines were being administered that people had to wait to be assisted.

At our previous inspection we found the service was not working within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. At this inspection we checked and found improvements had been made and appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made. We found mental capacity assessments were not all decision specific.

Staff were receiving supervision and there was an appraisal system in place. Staff had either received or

were in the process of receiving training appropriate to their roles to ensure they had the knowledge and skills to provide a good service.

People told us how much they enjoyed the food and they were offered choice at mealtimes. We found there was a delay in meals being served and people were sitting for a long period before being offered their meal. People were offered drinks and snacks throughout the day to ensure hydration and nutrition was maximised.

Staff knew how to support people in line with their views and preferences.

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy, dignity and confidentiality were protected at all times.

Recording practices had improved and people's records reflected the care they were receiving, with the exception of two areas. The recording of moving and handling practices and decision specific mental capacity assessments lacked the required detail to ensure the people living there were cared for appropriately.

We found at the time of our inspection organised activities had been planned. However, meaningful occupation at other times of the day for all the people living there was not evident during our inspection and we have made a recommendation about meaningful activities for people who live in care homes.

The home had a new manager in place who was not yet registered with the Care Quality Commission. Staff and relatives spoke highly of the new manager and their openness to suggestions for improvement. The registered provider had invested heavily in improving the home and its environment and in improving the quality of the service and we found that this was reflected by a positive atmosphere in the home amongst staff and people living there.

The home was monitoring the quality of the service provided and plans were on-going to raise the standards of care at Roberttown to ensure people's experience of living there was good.

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

Medicines had not always been administered safely.

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents

The service had assessed individuals in relation to risk and had put plans in place to reduce the risks.

Is the service effective?

Requires Improvement

The service was not always effective

Deprivation of Liberty Safeguards (DoLS) applications had been made appropriately to comply with the Mental Capacity Act 2005.

We found mental capacity assessments were not all decision specific.

People told us how much they enjoyed the food and they were offered choice at mealtimes.

Is the service caring?

Good

The service was caring

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy, dignity and confidentiality were protected at all times.

People who required advocacy were supported to make use of advocacy services to ensure they had someone to speak on their behalf.

Staff encouraged people to remain independent in their activities of daily living.

Is the service responsive?

Requires Improvement

The service was not always responsive

Staff knew how to support people in line with their views and preferences.

Recording practices had improved but we found a lack of detail in moving and handling care plans and decision specific mental capacity assessments.

Organised activities were planned but we found outside these arrangements there was a lack of meaningful occupation for people during the day.

Is the service well-led?

Requires Improvement

The service was not always well led

The registered provider had invested heavily in improving the quality of care and environment for people living at Roberttown. Our observations confirmed significant improvements had been made, but the changes had yet to be sustained.

Staff told us how improvements had been made and management were supportive

The service was undertaking audits and acting on these audits to ensure the quality of the service was improved.

Roberttown Care Home Limited

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 16 and 21 December 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before our inspection, we reviewed all the information we held about the home. The registered provided had not been asked to complete 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 contacted Healthwatch to see if they had undertaken a recent 'Enter and View' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They told us they had not undertaken a recent visit and they had not received any recent information relating to the service. We also contacted the local authority contracts department and safeguarding team to gather recent information about this service to inform the inspection process.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing care in the two communal lounge and dining areas. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the manager, the operations manager, head of care, a registered nurse, three care workers, the cook, a visiting dietician, social worker, and nurse reviewer during our inspection. We also spoke with 5 people who used the service and five visiting relatives.

We reviewed eight care files and documents relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

At our inspection in February 2015 we found the service had breached the regulations relating to the management of medicines. At this inspection we found significant improvements had been made, but we still found the systems in place for the management of medicines in the home were not robust and we found errors in the administration of medicines.

We inspected medication storage and administration procedures in the home. We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw the medicines refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures.

The majority of medicines were administered via a monitored dosage system supplied directly from a pharmacy. Some medicines were administered from individual named boxes which had not been dispensed in the monitored dosage system. Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation and are called controlled drugs. We saw that controlled drug records were accurately maintained and two appropriately trained staff administered the medicine and checked the remaining balance.

Creams and ointments were prescribed and dispensed on an individual basis. These were properly stored and dated upon opening and all medication was found to be in date. We saw evidence that people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on Medicines Administration Record sheets were signed by the GP and a member of nursing staff. We saw all 'as necessary' (PRN) medicines were supported by written instructions which described situations, frequency and presentations where PRN medicines could be given and any known allergies were recorded on the MAR sheet.

We observed a registered nurse whilst they conducted the morning medication round and medicines were given safely and people were sensitively helped to take their medicines. However constant interruptions which required the input of the nurse significantly delayed the medicine round. We commenced our observations at 08:55 and witnessed the last person received their morning medication at 12:40. This could potentially have compromised some people who required a second administration of the same medicine at lunchtime. For example one person was administered Metformin 500mgs at 10:55 yet was prescribed to be administered again with the lunchtime meal.

We carried out a random sample of eight boxed medicines and found anomalies on six occasions. We found one person had been prescribed four different medicines. The MAR sheet did not record the stock balance carried forward onto the new MAR sheet therefore we had no method of checking stock levels. We also found one person was prescribed Co-careldopa 25/100mgs five times a day in variable doses and our audit showed discrepancies between the signatures and the remaining stock levels. Two more tablets remained in stock than should have been indicating the daily variable dosage had not been adhered to.

We found the MAR sheets showed anomalies including missing signatures with regard to two medicines on five occasions in the week preceding our inspection. We also found one person was prescribed Co-careldopa 25/100mgs to be administered at night at 22:00 but on the day of our inspection this had been signed as administered at 09:30. An audit of stock levels showed 28 tablets had been dispensed with the first administration on the 12th December 2015. Therefore four tablets should have been administered but we found five tablets were missing which indicated the fifth tablet had been administered at some time.

Our observations indicated the administration of some medicines contained errors and the audit system was not sufficiently robust to pick up these errors. By the second day of inspection, the registered provider's regional nurse had reviewed all the systems in place and introduced changes including an audit twice a day by two different nurses and a change in paperwork to reduce the opportunity for errors. However, due to the errors found on our first day of inspection we found the location had breached regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and treatment as medicines were not always managed safely.

People who used the service told us the service was safe. One person said "I feel safe. I can press the buzzer 24 hours a day, but I don't call unless I have to. The girls handle things very well." All the relatives we spoke with told us their relations were safe. One relative told us their relation used to fall every day before they came to live at the home. They said "Now they no longer fall, are very settled and have put on weight".

We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff we spoke with described the types of abuse they might find in a care home such as financial, sexual, neglect and discrimination. They told us "any form of abuse is not acceptable" and they would escalate any concerns to the Head of Care, management, to safeguarding and to the Care Quality Commission if they felt it necessary. The manager told us they worked with all new staff to ensure they understood safeguarding and they would discuss scenarios in staff meetings.

The manager told us risk assessments were completed for risks to skin integrity, falls, risk in relation to bed rails, medication, isolation, activities, nutrition and feeding and evacuation. The assessments are undertaken by Head of Care and the clinical lead to minimise risks such as from choking, around mobility, wheelchair use and moving and handling. We found risk assessments in the care files we reviewed for choking, medication administration, moving and handling, falls, pressure ulcers and for the use of the bath hoist which demonstrated the home had a system in place for assessing and managing risk to the people living there. However, we did find the information relating to moving and handling lacked detail and this was discussed with the manager who told us they would ensure this documentation was improved.

The manager told us they had enough staff to meet the needs of the people who used the service. They told us there were always a nurse on duty and four care staff during the day and a nurse and two care staff during the night. The Head of Care told us they worked six days a week and the manager between five and six days a week. The staff we spoke with told us there were enough staff but meal times were very busy particularly breakfast time as most people chose to get up after night staff had finished so the day staff were supporting people to eat and also with personal care tasks. The manager told us they used a dependency tool to determine staffing levels, but they also discussed dependency levels with the Head of Care and the clinical lead to ensure they had the right staffing to meet the needs of the people using the service. The manager told us they used regular agency staff who were familiar with the service and the people who lived there. They told us they were trying to build up the number of bank staff on their books to reduce the use of agency staff and they had undertaken a recruitment drive and were awaiting references and Disclosure and Barring Service (DBS) checks for three new members of staff. They told us all new staff were on bank contracts

initially to ensure they had the right skills and behaviours to provide a quality service to the people living there before being offered a permanent contract.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. For example, we saw evidence in each file that Disclosure and Barring Services (DBS) checks had been undertaken and two references received for each person.

We examined accident and untoward incident records. We saw when people had sustained a minor injury a record of observations existed to ensure people fully recovered from their injury. The records also showed where an ambulance had been called, and whether there had been a need for hospitalisation. The manager told us they audited and analysed each incident to determine any themes.

Each person had a personal evacuation plan in each file. However, for those people who required assistance to move, the plans lacked the information on how these people were to be assisted. However, all the staff we spoke with were able to advise us how they would support people in the event of a fire. The manager told us they would ensure the plans reflected the technique required to support people to evacuate.

The home has a dedicated infection control lead and had been inspected recently by the health authority and had met the required standards. We observed one incident of poor infection control practice during our inspection which we raised with the manager. We completed a tour of the premises and inspected several bedrooms, toilets, bathrooms and various communal living spaces. The home has a new medication room, and the laundry has been refurbished. Two maintenance persons are employed by the home to ensure the premises were safe and refurbished for the people living there and the manager told us there had been many changes and investments to ensure the environment had improved from the previous inspection. All hot water taps were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. Heating to the home was provided by covered radiators, protecting vulnerable people from the risk of a burn from a hot surface. We saw fire-fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed and upstairs windows had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. We found all floor coverings were appropriate to the environment in which they were used; they were well fitted and as such did not pose a trip hazard.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we found the service had not met the requirements in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and also in relation to supporting and developing staff. At this inspection we found significant improvements had been made and these improvements were still ongoing.

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 three people were subject to authorised DoLS. Two of these people had conditions attached to the authorisation. Discussions with the manager and our observations of care and records in the care plan showed the conditions were being met.

We spoke with the manager about a further four authorisations recently submitted to the supervisory body. Our discussion demonstrated the manager had a good understanding of the requirements of Mental Capacity Act 2005 and the code of practice with regard to DoLS. We also spoke with the manager about the use of restraint which included the use of bed-rails. The manager demonstrated a good understanding of how inappropriate use of bed-rails may constitute unlawful restraint. We looked at two care plans for people with bed-rails in place. We saw appropriate risk assessments had been conducted prior to the use of bed-rails. We saw bed rails were correctly fitted to ensure people were not at risk of entrapment and were not used as a form of restraint.

We found all the staff at the service we spoke with had a good understanding around mental capacity to consent to care and how to follow a best interest process. One member of staff described how they supported one person who did not have capacity to choose what to wear on a daily basis and how they had sought advice from this person's relative who said the person would never wear a skirt, so the carer would always ensure they were dressed according to their previous known wishes.

We found evidence in all the care files we looked at that the two stage mental capacity assessments had been completed when a person might be considered to lack the mental capacity to make a decision. However, not all the assessments we reviewed were decision specific. We discussed with the manager the need for these to be specific to the situation being assessed. The manager assured us this would be addressed.

We found that one person's records indicated they may on occasions require their medicine to be administered covertly. However, we found the process for administering medicines covertly did not meet the requirements of the Mental Capacity Act 2005. There was no decision specific mental capacity assessment and we could find no evidence of a best interest meeting, nor of advice being gained from a pharmacist. We found a letter from the person's General Practitioner indicating the home should continue covert medication as per the decision in a letter from a previous General Practitioner at the home they lived in previously but there was no evidence of a formal process to support this administration. On the day of our inspection we observed this person accepted their medicines without the need for it to be administered covertly, so we did not observe any unlawful practice. We spoke with the manager who assured us a review of the current arrangements would be conducted as soon as possible strictly in accordance with the needs of the Mental Capacity Act 2005 and national guidance.

We looked at three staff files and associated records and found staff had completed a comprehensive induction. All new staff completed the Care Certificate or self-assessed against the Care Certificate if they had experience in providing social care. The manager had signed off all self-assessment documents and we saw evidence of this in one of the staff files we reviewed. Staff told us they shadowed other staff before being put on the rota. This showed us new staff were supported to develop into their roles.

The manager told us supervision was happening every other month. The registered provider had employed a regional nurse to assist in developing nursing staff in post and to ensure registered nurses would be ready for revalidation with the Nursing and Midwifery Council. Two members of staff we spoke with confirmed they had received regular supervision and had also had a recent appraisal. Regular supervision of staff is essential to ensure that the people at the service are provided with the highest standard of care by supporting staff to develop in their roles. We reviewed the supervision records of staff and noted most of these sessions were up to date. We also reviewed the training matrix for staff and found that staff had received mandatory training or had the training assigned. The manager told us staff had to complete some training on line and this had proved an issue for some staff. The service was to provide a designated training lap top for staff to use in the home to ensure this training was completed promptly.

We observed the lunchtime meals in both dining areas. Tables were laid out with table cloths, cutlery and condiments. In the upstairs dining area the provision of the lunch time meal was delayed and people were waiting patiently at their tables for over half an hour. Drinks were not available whilst people were waiting for their meal to be served and it was only when one person asked for a drink after their first course that the staff member noticed that not everyone had been offered a drink. This was in contrast to the rest of our inspection where we observed people being offered drinks and snacks throughout the day.

We observed food arriving in plates from the kitchen and people being offered a choice of food at the table. People told us how much they enjoyed the food. One person said "I enjoyed it. Potatoes, carrots and beef. Really simple, well cooked and enjoyable". Another person said "The gravy is lovely. She does a good gravy." However, the length of time people had to wait for their lunch in the upstairs dining room indicated there were insufficient staff to ensure the lunchtime experience was good. We found similar issues in the ground floor dining area, with those requiring support with feeding left unsupported for a long period of time. We raised our concerns with the manager who told us they would look at the deployment of staff as a priority.

Care plans we looked at showed people had been seen by a range of health care professionals, including the care home liaison team, speech and language therapist (SALT), occupational therapists, GP's, district nurses and opticians.

Good

Is the service caring?

Our findings

One person who lived at Roberttown told us "Staff are caring. They are thoughtful and considerate." We spoke with a relative of a person at the home who said, "The care here is very good. My [relative] came home with me yesterday but was happy when she was able to come back to Roberttown which [relative] considers to be home." Another relative told us, "It's good you are inspecting but I think it's good and I have nothing but praise for the staff." One relative we spoke with told us how good the communication between the home and themselves was and said "The home has been straight on the phone if [relative] needed to go to hospital. We spoke with a member of staff who told us "Staff care about the service users." Another said "We care about the people living here. It's a small home and you get to know the residents. We are their family."

The Head of Care told us they tried to speak to every person who lived there every day to be able to recognise any changes in their needs. We observed people were well dressed and clean which demonstrated staff had taken time to assist people with their personal care needs. We observed staff interaction with people throughout the day and found the staff were gentle, patient and respectful.

The manager advised us they were able to use the service of advocates for those people who did not have family to support them. They had a good insight into the requirements to provide unsupported people with advocacy. There was also an Independent Mental Capacity Advocate visiting a person on the day of our visit. This showed us the service was appropriately considering the use of advocacy services to ensure all the people living there were supported to express their views.

We saw people's privacy, dignity and human rights were respected. For example, staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care. This showed people were treated with respect and were provided with the opportunity to refuse or consent to their care and or treatment. One member of staff told us they always made sure bedroom doors were shut when undertaking personal care and if they were discussing a person over the telephone they would ensure confidentiality by closing the door to ensure they could not be overheard.

Staff told us they maximised people's independence by encouraging them to continue to undertake personal care tasks such as washing and dressing. One member of staff told us "I ask if they want to wash their hands and face and hand them the flannel. I would see what they can do before offering support."

We reviewed a random sample of four care plans which recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

Requires Improvement

Is the service responsive?

Our findings

Staff we spoke with demonstrated they were aware of the needs and preferences of the people they were supporting. They told us how they supported people to make choices in their everyday lives taking into account their views and preferences which demonstrated they were providing person centred care.

We spoke with the head of care who told us people who used the service were involved in their care planning. They told us they would sit with the person and go through the care plan with them to determine their likes and dislikes. For those people who lacked capacity and who could not express their view or preference the Head of Care told us they would go through the care plans with the person's family to make sure the plan was person centred to the individual.

If people's preferences changed over time, the care plan would be updated to reflect this change. For example, they told us a person who used to rise late, had now decided they wanted to get up early and these changes were made to facilitate their choice. This was all recorded in the person's care plans and they communicated to staff any changes in people's preferences on a daily basis during handover between shifts. The home used a designated form which had been recently changed to contain more information about the person as a prompt to staff and we found this information to be an effective means of communicating the needs of people using the service.

The manager told us people on respite and those who lived permanently at Roberttown had the same level of care planning. Previously people on respite had a shortened version of the care plan, but this had led to a lack of information on how to support the person. We reviewed eight care files as part of our inspection process. Each file contained a care plan which recorded what each person could do independently and identified areas where the person required support. The areas included mobilisation, toileting, nutrition, communications, mood, sleeping and personal hygiene. Each area of people's support needs was underpinned by a risk assessment. We saw staff recorded daily outcomes of the care plan and took steps to modify the plan in light of people's experiences or changing health care needs. Where people required support the care plan described this in terms of numbers of staff and any equipment needs. We did find the information relating to moving and handling lacked detail and by the second date of inspection the Head of Care showed us how this information was to be improved by using photographs to ensure staff appropriately handled people using approved techniques.

One person whose care file we reviewed had been assessed as being at high risk of developing pressure sores. We saw the care plan identified a number of actions required to mitigate the risks. We saw advice from District Nurses had been incorporated into care plans. Daily records of care delivery suggested action was being taken to reduce the risks of pressure sores and absence of sores or skin problems over the past eight months indicated the care provided had been effective for this person.

The manager told us they had introduced a document called "My routine" for people living with dementia. The home encouraged families to work with staff to enable them to understand the history of the person and understand their lives in order to be able to support them better. We saw that this had started although

the development of these records were at an early stage. However this type of recording would ensure care plans were person centred and contained the detail to ensure staff were about to appropriately and consistently care for people.

We also spoke with a visiting professional from the Clinical Commissioning Group (CCG) who was there to review one person on respite. They told us all the records they had asked to be completed such as weight recording, pressure area care and ABC (Antecedent-Behaviour-Consequence) charts which analysed behaviour corresponded to the person's daily records and presented an accurate record of the person's daily life.

We found some people's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bed room. Some people had wall paper on the walls of their rooms and we were told the manager had painted one person's room pink in time for their 90th birthday celebrations as they had shown a preference for a pink bedroom.

We asked the manager what activities were available at the home. We were told by the manager as it was approaching Christmas, people living at the home were to be supported to attend a nativity play the following day at a local school and extra staff had been brought in to support this activity. They were also to host a Christmas party the day after this and families of the people living there had all been invited to attend. The local church choir was to also visit the following week and the home also booked in regular external entertainers. One person who lived there told us they were happy to watch television, but they would take part in activities depending what was on and what activities had been planned.

One relative we spoke with praised the caring staff for sitting and talking with their relative. They said the staff member had asked them to bring in a colouring book and jigsaw so they could support the person with this. We found in some of the care plans we looked at, there were very few activities recorded. For example, in one person's records only three activities had been recorded as completed in October 2015. We raised this with the manager who felt this was a recording issue as not all staff recognised what constituted an activity and where this should be recorded. We recommended the manager considered utilising nationally recognised guidance on ensuring wellbeing through activity in care homes to ensure all the people living there were supported to have meaningful occupation throughout their day.

We reviewed the complaint system with the manager and these had been concluded appropriately. There was one outstanding complaint from a family member who no longer lived at the home. At the time of the inspection an outcome had not been achieved but the manager did explain to us how they had investigated this complaint. This matter was also being investigated by the local authority safeguarding team and this had not been concluded at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the home had breached the regulation relating to monitoring the quality of the service. At this inspection we found improvements had been made. The manager had been in post for three months at the time of our inspection. They were in the process of registering with the Care Quality Commission. The registered manager had left six months prior to the inspection and an interim manager had been in place between the registered manager's departure and the new manager taking up the position. Therefore at the time of this inspection, improvements had been made but it was too early to determine the long term impact of the changes.

Staff spoke positively about the manager, the operations manager and the head of care. One member of staff told us "The manager's door is always open. They listen and things get sorted within 24 hours". One relative told us "the management is excellent. They have always been receptive to our observations and are very professional in meetings."

The manager shared their vision of the service and told us they were aiming ultimately to provide an outstanding rated service. They described the culture of the organisation in terms of openness and increasingly positive. The manager told us they monitored the quality of the service by undertaking frequent walk arounds at the service, and they kept their office door open to be aware of what was going on in the downstairs communal area. They told us staff practice was regularly observed and we saw evidence of one observation. They told us they led by example, and showed staff that they would undertake any task such as laundry and cleaning if it ensured the smooth running of the service. They told us they encouraged involvement at all levels of staffing and they listened to staff and took on board what staff said in regards to ensuring improvements were made at the home. They told us they would not accept poor quality care and were in the process of performance managing some staff to ensure the drive to a quality service. The Head of Care told us all the staff share the same vision as the manager and want the home to be recognised as a good service. They told us they were aware they were not there yet, but they were improving all the time. They wanted "every family to walk away knowing their mum and dad were well looked after." The staff we spoke with also shared the same vision.

The registered provider had a quality management team which was focussing on raising the quality of the service. This involved setting out clear expectations for staff on what was expected of them and the importance of the experiences of the people living at the home. The operations manager told us they regularly visited the home and they undertook a detailed audit of the service and they had put in place actions to ensure standards continued to improve. The manager showed us their audit from November 2015 which detailed an audit against the Care Quality Commission fundamental standards and key lines of enquiry in relation to the provision of safe, effective, responsive and well led care. This contained actions, person responsible for the action, the time scale and when the action had been completed. The content of the audit demonstrated the service was monitoring the quality of service provision and ensuring actions were completed.

The manager undertook regular audits of the call bells following a safeguarding concern where it had been concluded there was a potential the calls bell battery life could expire. They officially audited the call bells monthly but also undertook a weekly check of call bells and staff response time. We inspected records relating to the maintenance of the building and services and we found the passenger lift, gas safety, electrical installations, water quality, hoists and slings and fire detection systems had all been correctly inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out.

We were shown the minutes of the last two staff meeting which had taken place in October and November 2015. Items on the agenda included quality and standards, infection control, maintenance, confidentiality, dress code, health and safety, record keeping, whistleblowing and fire evacuation and training and the minutes detailed the meetings had been informative and an opportunity to communicate with staff. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service.

The manager told us they were trying to build links with the local community and volunteers. This included building links with the local church and rebuilding links with the local school. They were trying to encourage family members past and present to become involved with the home. The manager also took part in the local authority provider forum meeting, safeguarding meetings and the local authority training events and opportunities. The home had recently published a newsletter detailing what was going on at the home for the month of December 2015. This demonstrated the home was striving to involve and be involved in the area.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The administration of some medicines contained errors and the audit system was not sufficiently robust to pick up these errors.