Parkhaven Trust

Kyffin Taylor

Inspection report

Parkhaven Trust
Deyes Lane
Maghull
Merseyside
L31 6DJ

Tel: 01515272822
Website: www.parkhaven.org.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 23 and 24 March 2016 and was unannounced.

Kyffin Taylor is a residential care home located in Maghull. The home provides accommodation and personal care for up to 29 people, the majority of whom have dementia. The building has 21 rooms on the ground floor and eight on the first floor. There is a car park at the front of the home and secure, well maintained gardens at the rear. On the day of inspection there were 28 people living in the home.

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

Medicines were not always managed safely within the home. For instance, there were gaps observed in the recording of administered medicines and room temperatures where medicines were stored were not monitored; however fridge temperatures were monitored and recorded but were not within safe ranges. Medicines were not always administered in line with safe administration guidance.

All people we spoke with told us they felt safe living at Kyffin Taylor and relatives agreed. One person told us, "I feel very safe here" and another person told us, "They are all kind to us, I feel very safe."

We found that there was an effective procedure in place to recruit staff and there were adequate numbers of staff on duty to meet people's needs.

Care files showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. Staff had completed training in relation to safeguarding and had a good understanding of how to report concerns. A small number of safeguarding incidents had not been reported.

We looked at accident and incident reporting within the home and found that accidents were reported appropriately. Measures were in place to ensure the environment was safe and well maintained, including equipment used within the home.

We found that people's consent was usually sought in line with the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS) were applied for appropriately.

Staff received an induction into their role and completed regular training to help ensure they had the knowledge and skills to meet people's needs. Not all staff had received supervision in the last few months, however staff told us they felt well supported.

When asked about the food we received mixed feedback. People told us the food was nice but that they did not always get a choice in what they ate, but that alternatives were available should they not like the meal offered.

Some adaptations had been made to the environment to assist people with orientation and safety, such as pictoral signs. This meant that people's independence and safety was promoted within the home.

People living at the home told us staff were kind and caring and treated them with respect and relatives we spoke with agreed. Staff knew the people they were caring for well, including their needs and preferences. Interactions between staff and people living in the home were warm and caring.

People we spoke with told us their relatives visited frequently and relatives we spoke with were happy with the visiting arrangements. People were happy with the care they received and relatives were involved in the care planning process. Care plans were in place which offered guidance on how to support people, but some lacked sufficient detail.

Preadmission assessments were completed to ensure people's needs could be met as soon as they moved into the home.

Activities were available for people to participate in, such as quizzes, games and singing.

People were able to share their views through quality assurance surveys and regular meetings and had access to a complaints procedure. A process was in place to manage complaints, forms were available for people to use and relatives we spoke with were aware how to raise concerns should they need to.

Systems were in place to monitor the quality and safety of the service, however they did not pick up on all of the issues highlighted during the inspection. We also found gaps in the recording of some care provision, such as repositioning records and dietary charts were not always completed accurately.

We asked people their views of how the home was managed and feedback was positive. All people we spoke with felt able to raise concerns should they need to and were confident that they would be listened to.

Although the registered manager had notified CQC of some events and incidents within the home in accordance with our statutory notifications, they had not notified us of all safeguarding referrals that had been made.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff had completed training in relation to safeguarding and had a good understanding of how to report concerns. A small number of safeguarding incidents that had not been reported.

Medicines were not always stored and managed safely within the home.

People we spoke with told us they felt safe living at Kyffin Taylor and relatives agreed.

We found that there was an effective procedure in place to recruit staff and there were adequate numbers of staff on duty to meet people's needs.

Care files showed that risk assessments had been completed to assess and monitor people's health and safety and measures were in place to ensure the environment was safe and well maintained.

Is the service effective?

Good

The service was effective.

People's consent was usually sought in line with the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS) were applied for appropriately.

Staff received an induction into their role and completed regular training. Staff told us they were well supported.

People told us the food was nice but that they did not always get an initial choice of meal, but that alternatives were available should they not like the meal offered.

Some adaptations had been made to the environment to assist people with orientation and safety, such as pictoral signs.

Is the service caring?

Good

The service was caring.

People living at the home told us staff were kind and caring and treated them with respect and relatives we spoke with agreed.

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

Interactions between staff and people living in the home were warm and caring.

People we spoke with told us their relatives visited frequently and relatives we spoke with were happy with the visiting arrangements.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were gaps in the recording of some care provision and dietary charts were not always completed accurately. Some care plans lacked sufficient detail and were not person centered.

Care plans in place were reviewed regularly.

Pre-admission assessments were completed to ensure people's needs could be met as soon as they moved into the home.

Activities were available for people to participate in, such as quizzes, games and singing.

People were able to share their views through quality assurance surveys and regular meetings and had access to a complaints procedure.

Is the service well-led?

Requires Improvement

The service was not always well –led.

Systems were in place to monitor the quality and safety of the service, however they did not pick up on all of the issues highlighted during the inspection.

Feedback regarding the management of the home was positive.

The registered manager had not notified CQC of some events and incidents within the home that they should have.

Kyffin Taylor

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 23 and 24 March 2016 and was unannounced. The inspection team included two adult social care inspectors.

Before our inspection we reviewed the information we held about the home. This included a review of the Provider Information Return (PIR). The PIR 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 looked at the notifications the Care Quality Commission (CQC) had received from the service and we spoke with the commissioners of the service.

During the inspection we spoke with the registered manager, five people living in the home, three relatives and five members of the staff team.

We looked at the care files of five people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink).

The registered manager told us nobody was receiving covert medicines at the time of the inspection; however a carer told us they had tried to administer medicines covertly to a person who had been refusing their medicines as they knew the medicines were important. The GP had been made aware the person was refusing their medicines and was due to visit the person. There were no agreements in place to administer the person's medicines covertly or whether it was safe to do so. This meant that medicines had not been administered in line with current guidance or the policy within the home.

We reviewed the MAR charts and found that there were a number of gaps in the recording of medicine administration. This meant that there was not always clear records of medicines people had been administered.

One medicine contained directions that it had to be administered 30 minutes prior to eating. A carer we spoke with told us they administered this medicine with all of the person's other medicines after breakfast. We discussed this with the registered manager who stated staff knew this had to be administered prior to eating and would ensure it was administered as directed.

We reviewed the storage of medicines and found that room temperatures where medicines were stored were not monitored; however fridge temperatures were monitored and recorded. The fridge temperature on the day of inspection was 0 degrees and so was not within the recommended limits. We reviewed the records and found that temperatures had not been within range for a number of days. Staff we spoke with knew the safe temperature ranges for the medicine fridge. The fridge contained insulin and we discussed this with the registered manager who contacted the pharmacy for advice regarding whether it was safe to use the insulin and were advised by the pharmacist to discard the medicine. We observed medicine trolleys stored in the lounge during the inspection and these were not secured to the wall. The registered manager told us the trolleys were usually stored in the medicine room when not in use.

We observed a carer administer a controlled medicine without checking the MAR chart or completing the controlled medicines register. This was not in line with safe administration guidance. The controlled drugs register also showed that the same medicine had been given earlier the same day and had not been countersigned by a second staff member. One carer told us they did not always have time to find another carer to check the medicine and sign the register. Care staff told us they were often called upon for other tasks whilst administering medicines, such as phone calls or visits from health professionals and felt this was a distraction. We discussed this with the registered manager as distractions whilst administering medicines could lead to errors and they agreed to look at ways of reducing distractions to staff during these

times.

We looked at staff training in relation to medicine administration and found that there were occasions when none of the staff on duty overnight were trained in medicine administration. The registered manager told us people did not usually require medicines overnight and that there was always somebody on call. On the day of the inspection a person's medicines had been reviewed and they would require medicines overnight and the rota showed that the staff on duty were not trained to administer medicines. The registered manager told us the staff had completed in house training but had not had their competency assessed. The registered manager agreed to assess the staff member's competency that day before they commenced their shift, to ensure people's needs could be met overnight.

This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. All staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. Staff had completed training in relation to safeguarding and interview records showed that staff were asked to respond to scenario type questions regarding safeguarding in order to establish their understanding. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the home. This enabled referrals to be made to the relevant organisations. We found that a small number of safeguarding incidents had not been reported. We discussed this with the registered manager who told us they would ensure staff received refresher training and would look at ways of improving the system to ensure all relevant incidents were reported as required.

We recommend that the provider takes into account local guidance in relation to adult safeguarding and updates their practices accordingly.

All people we spoke with told us they felt safe living at Kyffin Taylor and relatives agreed. One person told us, "I feel very safe here" and another person told us, "They are all kind to us, I feel very safe."

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

We looked at how the home was staffed. On the first day of inspection there were six members of the care team on duty, as well as a cook, a kitchen assistant and domestic staff. The manager explained this was the usual number of staff of a morning and in the afternoon there would be five care staff and three overnight. The staff rota's we observed showed these staffing levels were consistent. The registered manager told us they did not use dependency assessments or staffing analysis tools to determine the number of staff required to meet people's needs, but did change the staffing numbers based on people's needs.

Most staff, relatives and people living in the home that we spoke with, told us there were adequate numbers of staff on duty, though they could be very busy at times. We observed staff providing support to people in a timely way during the inspection, such as when people required support with personal care. At lunch time we observed people being supported to eat their meal and they were not rushed.

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

We looked at accident and incident reporting within the home and found that accidents were reported appropriately. An audit of incidents was completed quarterly to identify any potential trends, such as times and location of incidents. This enabled the registered manager to implement appropriate measures to reduce the potential of future accidents within the home. Specific incident forms had been developed for use following falls. These completed forms provided detailed information regarding the fall and actions taken following the fall, such as medical advice, referrals to the falls team and whether further reporting was required.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. Staff we spoke with had a good understanding of fire safety and the process of evacuating the home should it be required. Records however, showed that a fire drill was last recorded in January 2015 for day staff and last completed in 2014 for night staff. The registered manager agreed to ensure all staff completed regular fire drills to ensure they could safely support people in the event of an emergency.

Audits in areas such as health and safety and maintenance of the building had been completed to ensure the environment remained safe.

External safety checks had been completed to help ensure the safety of the building and equipment. We saw certificates for areas such as gas, emergency lighting, water, hoists and slings, fire equipment and electrical equipment. These were in date.

There were no concerns raised regarding the cleanliness of the home. We observed personal protective equipment being worn appropriately by the staff and cleaning audits were completed regularly. There was hand gel available and bathrooms contained liquid soap and paper towels in accordance with infection control guidance.

Good

Is the service effective?

Our findings

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

The registered manager told us that they had made a number of DoLS applications and that 14 had been authorised. These authorisations were viewed within people's care files and the manager had a system in place to monitor expiry dates to ensure new applications were made at the correct time. Staff we spoke with had an understanding of DoLS and who this applied to within the home.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, before entering a person's bedroom, providing personal care and providing support at lunch time. Records we looked at showed that when able, people signed consent forms in areas such as photography, access to care files and outings.

When people were unable to provide consent, it was clear that people's family were involved in decisions regarding care and were involved in the care planning process. It was not always clear however, who had been involved in the discussions. Staff had signed consent forms for some people in areas such as photography and these records stated they were signed with agreement but not who this had been discussed with. The registered manager agreed to ensure this was clearly recorded within care plans.

Mental capacity assessments were completed when required, and these were detailed and followed the principles of the Mental Capacity Act 2005, including clear best interest decisions. For instance, one person's care file contained a mental capacity assessment to establish whether the person was able to consent to living in the care home. As they were unable to consent, a best interest discussion was recorded with family members and the outcomes recorded, such as an application to be made for a DoLS authorisation, which had been completed.

We looked at staff personnel files to establish how staff were inducted into their job role. The staff files we viewed showed that staff had received an induction which covered areas such as the homes policies and procedures, mandatory training and health and safety information and staff we spoke with confirmed this. One file contained completed care standards induction and the registered manager told us they had recently updated their e-learning induction training to ensure it met the requirements of the care certificate. The care certificate is an identified set of standards that health and social care workers should adhere to in their daily working life.

We looked at ongoing staff training and support. Staff told us they felt well supported and received supervision every two to three months and an annual appraisal. Records we viewed showed that most staff had received supervision within the last three months, however not all staff had. The registered manager told us some supervisions were overdue and that responsibility for these had been shared out to some senior care staff in order to ensure people received supervision regularly. A system was in place to monitor supervisions and appraisals and help to ensure staff received relevant support to assist them in their roles.

Staff told us they had access to regular training and records showed that staff had completed training in areas such as safeguarding, moving and handling, fire safety and infection control. The registered manager told us external training had also been sourced, in areas such as nutrition, dementia and managing challenging behaviour. Four staff members were undertaking the six steps end of life training and six staff were completing a challenging behaviour course accredited by Sterling University. One relative told us, "Staff are amazing and well trained." This meant that staff had access to the knowledge and skills necessary to meet people's needs and ensure their safety and wellbeing.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the G.P, physiotherapist, dietician, social worker, community mental health team and the district nurses. People we spoke with and their relatives told us staff responded appropriately if they were unwell. One person told us, "I get to see the doctor whenever I need to."

We observed the lunch time meal in the dining room and found that tables were set and drinks of juice and tea were available to people throughout their meal. People who required support were provided with this in a dignified way. There was a pictoral menu board in the dining room but this was not fully completed on the day of the inspection. The registered manager had also compiled a file of pictoral meals which could be used to help people make choices when they had difficulty expressing this.

When asked about the food we received mixed feedback. People told us the food was nice but that they did not always get a choice in what they ate. People told us they were given a meal and that if they did not like it they would then be offered an alternative such as a sandwich. One person told us, "We don't get a choice. I get plenty to drink." A relative told us, "The food's very good, but I don't think [relative] gets a choice." Staff agreed and told us, "If you don't eat it cook will give you an alternative" and another staff member told us, "There's a limited choice. You can have a sandwich if you don't like the main meal."

This lack of choice was reflected in the quality assurance surveys that we viewed and had also been highlighted during an internal audit. Menu's reflected that alternatives were available if required and people were aware of this. The registered manager told us they had discussed this with higher management and would continue to look at ways to ensure people had an initial choice of meal, rather than providing an alternative if they did not like what was provided.

We observed the environment of the home and found that the manager had taken steps within the home for people living with dementia, towards the environment being appropriate to assist people with orientation and safety. For instance, bathroom doors had been painted yellow and there were pictures of toilets on the doors as well as the written word. An orientation board provided information such as the date and day of the week. There were interactive boards on the walls along the corridors which offered stimulation and people had different coloured bedroom doors as well as photographs to help people identify their room. This meant that people's independence and safety was promoted within the home.

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. Staff were described as, "Nice" and a person told us, "They [staff] are all very kind to us." Relatives agreed and one relative told us they, "Give staff full credit, they are excellent" and another relative said, "The staff are great here."

We observed staff respecting people's dignity and privacy in a number of ways during the inspection, such as referring to people by their preferred name and knocking on people's door before entering their rooms. Staff supported people with personal care activities in private and people did not have to wait long if they needed support. People were given plenty of time to eat their meals; they were not rushed in any way. Interactions between staff and people living in the home were warm and caring. Staff we spoke with shared examples of how they maintained people's dignity whilst providing support.

We found on discussion, that staff knew the people they were caring for well, including their needs and preferences. Staff told us they were allocated keyworkers for people and this helped them to get to know people well. We observed staff encouraging a person to eat at lunchtime and as the person was refusing the meal, staff offered other foods they knew the person enjoyed and they ate well.

Care plans contained some information regarding people's preferences. For instance, one person's care file recorded that they liked to have their handbag with them at all times. Another person's plan provided guidance to staff on what they could do to support the person when they were distressed, such as walking with them and turning on some music as this is what they enjoyed. Most care plans we viewed contained a "This is me" document which provided information about the person and what is important to them. This meant that the people were supported by staff who knew them and their preferences.

Interactions between staff and people living in the home were warm and caring, for instance we heard a carer supporting a person that was confused and becoming upset. The carer reassured the person and helped them to feel more settled by talking with them about their family and suggesting they go to the lounge and get a cup of tea. We also observed staff supporting people to mobilise into another lounge to take part in the entertainment that was arranged for the afternoon. This support was provided in a gentle and relaxed manner.

Most care plans we viewed showed that people and their families had been involved in the creation of care plans. Care plans were written in a way that promoted people's independence, such as advising staff to encourage people to assist themselves when possible and help people to make their own choices, such as what to wear. Care files were stored securely in the registered manager's office in order to maintain people's confidentiality.

We observed relatives visiting throughout both days of the inspection. The manager told us there were no restrictions in visiting, though they did encourage relatives not to visit at meal times unless they were joining their family member for a meal. People we spoke with told us their relatives visited frequently and relatives

we spoke with were happy with the visiting arrangements. One relative told us, "I can come at any time" and another relative said, "[Staff] don't like you to come at meal times but I am happy with that."

For people who had no family or friends to represent them, local advocacy service details were held by the manager and available within the home for people to access. The registered manager told us there was one person who received support from an advocate and that they liaised with social workers if they felt people would benefit from advocacy support.

Requires Improvement

Is the service responsive?

Our findings

We found that some care plans lacked sufficient detail regarding the support people required. For instance, one care file reflected that a person could become agitated and their medicine care plan advised staff to administer medicine as needed for this. The person's behaviour care plan advised staff to look for signs of agitation and administer medicine when needed, provide reassurance and try to divert the person's attention to assist them to become less agitated. There was no detail as to what signs of agitation the person may display, at what point to administer the medicine to help reduce agitation, or what diversion techniques may be successful for the person. Although staff we spoke with knew people they were caring for, not all staff may have access to relevant information to help support people effectively. We discussed this with the registered manager who agreed to review the care plans and ensure they provided staff with clear guidance on how to meet people's needs.

We also found gaps in the recording of some care provision, such as repositioning records. One person required support to reposition every two hours; however records showed that there was no record of the support for up to 15 hours on some occasions. The manager told us the person did not have a pressure ulcer but did have a lesion due to incontinence and was being supported on a pressure relieving mattress. The person was unable to tell us whether they received regular support due to memory problems.

Dietary charts were not always completed accurately. For instance, we observed one person eating soup and cornflakes at lunchtime on the first day of inspection, yet when the records were reviewed on the second day of inspection, only the soup had been recorded. This meant that records did not accurately reflect the support people had received and that the systems in place to monitor the quality and safety of the service were not effective. The manager agreed to provide a teaching session to all staff regarding the completion of accurate records.

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

We looked at how people were involved in their care planning. People we spoke with told us they were happy with the care they received and relatives agreed. One relative told us the care their family member had received had, "Really helped them." Care files we viewed showed that people and their families had been involved in the creation of care plans. For example, one care file included care plans that had each been read by the person's relative and suggested changes made before signing each care plan.

Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing and care files we viewed contained a record of communication between staff and people's relatives. This helped to ensure relevant people were involved in people's care.

We observed care plans in areas such as personal care, mobility, nutrition, spiritual wellbeing, behaviour, medicines, end of life wishes and skin integrity, as well as health specific care plans such as diabetes. Most care plans were detailed and contained information to guide staff on how to support people. For example,

one care file included a care plan regarding diabetes, signs to look for and requirements such as for the person to eat a low sugar diet.

All care plans we viewed were reviewed regularly by staff and most contained up to date information regarding people's care needs. For instance, following a fall a person's risk assessment had been reviewed and fall detection equipment had been supplied. This had been updated within the plan of care to ensure staff were aware of the change in need. Six monthly reviews were also completed and some relatives were involved in these.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff, viewing people's care files, daily notes and use of a communication book. The manager had also recently implemented a written handover sheet which included relevant information about the support provided to each person that day. This helped to ensure that all staff would have the information necessary to support people safely. Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission. A relative we spoke with told us staff had visited them at home before their relative moved into Kyffin Taylor and this visit, "Made them feel [relative] would be safe and well looked after."

We asked people to tell us about the social aspects of the home and how they spent their time and feedback regarding this was mainly positive. Relatives we spoke with were aware that activities took place, especially singers and events that were organised within the home, such as the Christmas fayre. People we spoke with told us about the upcoming Easter fayre and were looking forward to that. An activities coordinator was employed three days per week and the manager told us that staff were also responsible for providing activities on other days. We saw a schedule the registered manager had developed, identifying which staff provided activities each day. Staff we spoke with told us they were involved with activities and provided armchair exercises, games and pamper sessions.

The activities coordinator told us they involved people in decisions about activities as much as possible. They develop activities based on people's interests and abilities and currently have regular film quizzes then watch a film of choice, have arts and crafts and take people out to local attractions, such as garden centers. During the two days of the inspection, we observed people having their nails painted, participating in games in the lounge and an external entertainer that came in who sang and encouraged people to join in.

We looked at processes in place to gather feedback from people and listen to their views. The registered manager told us they arranged regular resident and relative meetings, and although they were not always well attended, the manager had an open door policy and had daily discussions with relatives. Relatives we spoke with were aware of the meetings and told us they could speak with the manager when they needed to.

Quality assurance surveys were provided to service users, their relatives, staff and visiting professionals on a regular basis, in order to gather their views regarding the service. Results were displayed within the home and information was available which showed actions that had been taken based on the feedback received, such as a review of the menu and creation of a pictoral menu to help people when choosing meals.

People told us they had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges, whether to join in activities or spend time in their rooms. Care files evidenced people's choice

with regards to personal care. A relative told us their family member preferred male staff not to stay in the bathroom with them and that this was respected by staff. Staff we spoke with agreed and one staff member told us, "We always ask people if they have a preference of male or female staff to help with their personal care."

As a number of people living in the home were unable to use call bells in their room to request support due to memory problems, the registered manager had installed technology to alert staff when people where up out of bed at night. This meant that staff could respond quickly and check people were safe and well, particularly people who may be at risk of falling.

People had access to a complaints procedure and this was displayed on notice boards within the home. The registered manager told us any complaints were sent to the head office who investigated and provided responses. A process was in place to manage complaints, forms were available for people to use and relatives we spoke with were aware how to raise concerns should they need to. One relative told us, "I can raise issues, and do. I am listened to and issues get addressed."

Requires Improvement

Is the service well-led?

Our findings

During the inspection we looked at how the manager and provider ensured the quality and safety of the service provided. A trustee from the company visited every three months and assessed the service in areas such as medicines, care plans and human resources. Recommendations were made which the registered manager then completed. The estate manager reviewed the premises and the internal quality assurance lead visited and, along with the registered manager, completed audits to assess the quality and safety of the service.

We viewed completed audits in areas such as health and safety, accidents, medicines, care planning, maintenance and infection control. This meant that systems were in place to monitor the quality and safety of the service. We found however, that these systems did not pick up on all of the issues highlighted during the inspection, such as those relating to medicines management. The medicine audits did not identify any concerns with management of medicines within the home and the manager agreed to complete more regular audits until the concerns had been addressed.

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

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. One relative told us the registered manager was, "Approachable" and staff we spoke with described them as, "Very approachable", "Helpful" and told us they, "Lead by example." All people we spoke with felt able to raise concerns should they need to and were confident that they would be listened to.

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

We looked at processes in place to gather feedback from people and listen to their views. As well as resident and relative meetings and quality assurance surveys, there were also regular staff meetings held to ensure views were gathered from staff. Records we viewed showed that staff meetings took place and covered areas such as fire safety, new policies and any new procedures implemented within the home.

A house newsletter had been developed as a way of ensuring people knew what was happening within the home. This included information on activities available, welcomed new service users, a summary of what has gone on in the home over the past month and also contained a section on health and wellbeing. The most recent newsletter contained advice and information regarding dementia.

A staff newsletter had also been created. This included employee of the month and any staff news, such as new births and certificates staff had achieved.

Although the registered manager had notified CQC of some events and incidents within the home in accordance with our statutory notifications, they had not notified us of all safeguarding referrals that had been made. This meant that CQC were unable to accurately assess risks regarding the service. The manager agreed to submit these notifications and on the second day of inspection, these had been completed.

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 17 HSCA RA Regulations 2014 Good governance Audits in place did not identify all of the issues we highlighted during the inspection, such as those relating to medicines. Records were not always completed accurately and contain up to date information regarding care needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored or managed safely.

The enforcement action we took:

warning notice