Macleod Pinsent Care Homes Ltd

Conifer Lodge

Inspection report

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Date of inspection visit:
29 September 2016

Date of publication:
03 November 2016

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

Summary of findings

Overall summary

Conifer Lodge is registered to provide personal care and accommodation for up to 26 people. It specialises in providing support of older people. On the day of the inspection there were 21 people using the service some of whom were living with the early stages of dementia and other health care conditions such as heart disease and diabetes. The service is made up of three combined properties over three floors. Some rooms at higher levels were accessed by a stair lift and some were only accessed by stairs making them unsuitable for some people with mobility difficulties. There was level access throughout the ground floor and to a secure rear garden.

This comprehensive inspection took place on the 29 September 2016 and was unannounced.

The service had a registered manager. 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 comprehensive inspection in 8 July 2015 we identified there was a quality assurance system in place to monitor quality and identify areas for improvement. However this did not include the auditing of care plans. We identified this as an area of practice that needed to improve. At this inspection we identified that a care plan audit had been introduced, but this had not been consistently completed and had not always been effective in identifying shortfalls and bringing about improvements.

At the last inspection we identified that staffing levels were not systematically being reviewed and assessed to determine whether they were sufficient to meet people's needs and this needed improvement. At this inspection people's dependency levels were being assessed, however this had not happened as often as the provider required and staffing levels had not been reviewed in line with the providers own protocol. Therefore the provider could not be assured the staffing levels were sufficient to provide responsive care.

At this inspection we identified a range of shortfalls in relation the administration of medicines and the completion of the associated medicine administration records. Audits of medicines and medication records had not been completed on a monthly basis as the provider required and the audits that had been completed had not been effective in identifying shortfalls. Therefore opportunities to identify and rectify shortfalls in the administration of medicines and drive improvement had been missed.

At the last inspection assessed improvements were needed in relation to providing and recording people's involvement in meaningful activities. At this inspection we identified that improvements had been made.

At the last inspection we identified that the risk of people falling had not been assessed and was an area of practice that needed improvement. At this inspection we identified this had been addressed.

People were supported to live the life they chose and their freedom was not restricted. There was a positive approach to risk taking and people were encouraged to remain independent and we observed people coming and going throughout the day going about their own business. One staff member told us, "We let people live their lives here". Another staff member said, "If someone wants to do their own thing, like go out, we don't stop them".

There was an hour's daily activity on offer each afternoon such as a quiz, baking or general discussion between people. Entertainers such as musicians and singers also visited the service and occasional trips out were organised. There were regular visits to the service by the local church and people had the opportunity to go on bus trips organised by an external provider.

People were supported to eat and drink sufficient amounts and they told us they enjoyed the food provided. Special diets were catered for and drinks and snacks were freely available throughout the day. People were provided with appropriate levels of support at meal times.

People's privacy was protected and people were treated with dignity and respect by kind and caring staff. One person told us, "The care staff are very good, I'm quite content here". Visitors were welcomed and people had the opportunity to attend meetings at which they could give their views on the running of the service and make suggestions for improvements. People were able to personalise their rooms and bring their own furniture and one person had brought their pet budgies when they moved in.

People's health care needs were met and professional advice and support was sought from health care professionals such as GP's and district nurses as and when needed. People were supported by competent staff who received the training and support they needed to undertake their role and effectively meet people's needs. One person told us they were happy with all the staff and felt a particular member of staff was, "Very efficient". Another person told us they received the support from staff that they needed and commented, "(Staff members' name) knows what I like and knows what I need".

Measures were in place to reduce the risk of harm occurring and protect people from abuse. Accidents were recorded, collated and analysed to identify themes and trends so that the provider could take steps to reduce the risk of reoccurrence. Staff understood the need to gain consent and worked in accordance with the Mental Capacity Act (MCA).

There were processes in place for complaints to be responded to. People told us they would speak with the registered manager or a member of the care staff team if they had any concerns or wanted to make a complaint and one person commented, "They listen to me".

Recruitment procedures were robust and included identity and security checks were completed before staff were deployed. All new staff completed an induction to the service and were introduced to people before they worked unsupervised.

People and staff felt supported by the management. The registered manager was aware of their legal responsibilities and kept up to date with good practice by attending management meetings with the area manager and other registered managers and providers of other services.

There were two areas where the provider was not meeting the requirements of the law. You can see what action we have asked the provider to take at the back of the full version of this 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 consistently safe.

The management of medicines was not consistently safe. The stocks of some medicines did not balance with the records, and medication administration records had not always been completed accurately.

Suspected abuse had been reported to the local authority in line with local protocol and staff had received training in protecting adults at risk.

Risks to people's safety had been identified and measures were put in place to reduce these risks as far as possible.

Recruitment practices were robust and staff were deployed sufficiently to deliver safe care.

Is the service effective?

Good

The service was effective.

There were systems in place to ensure that staff received the induction, training and support they needed to meet people's needs effectively.

People were supported to access healthcare support when needed.

Staff had a good understanding of the MCA and worked in accordance with legal requirements.

People's nutritional needs were met and people could choose what to eat and drink on a daily basis.

Is the service caring?

Good

The service was caring.

People were supported to be independent by kind and caring staff.

People were treated with dignity and respect.

Visitors were welcomed into the service and visiting was not restricted.

Is the service responsive?

Good

The service was not consistently responsive.

A range of daily activities were available however, some people felt bored and records did not always reflect how people spent their time.

Staff had access to plans for how people needed and wanted to be supported however some plans contained gaps and needed improving.

Staff knew people well and were knowledgeable about their support needs.

There were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The providers systems and processes for assessing and monitoring the quality of the services provided and to drive improvement had not been consistently applied. Audits that had been completed were not always effective.

Management were approachable and the registered manager was aware of their legal responsibilities.

The registered manager kept up to date with good practice.

Conifer Lodge

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 comprehensive inspection took place on 29 September 2016. Two inspectors and an expert by experience completed this inspection. An expert by experience is a person who has experience of this type of service.

At the last inspection of this service on the 8 July 2015 we identified areas of practice in relation to falls risk assessments, activities and quality assurance that needed improvement. At this inspection we checked to see if these improvements had been made.

Before the inspection we reviewed the information we held about the service and the statutory notifications they had sent us. A notification is a form that the provider completes to inform us about incidents that have occurred which they are required to tell us about by law. The provider had also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we observed the care being delivered at meal times. We observed staff administering medicines and observed the interactions between people throughout the day. We spoke with seven people who used the service, the registered manager, two team leaders, two care staff, two visiting relatives. We looked at five people's care plans, eight people's medication records, the staff duty rota, four staff recruitment files, meeting minutes, the complaints log, accident and incident records, an overview of training that staff had completed and an overview of the supervisions and annual appraisals that had taken place. We also looked at some of the providers' health and safety records and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe and secure living at the service and were happy with the arrangements in place for the administration of their medicines. However we identified shortfalls in relation to the management and administration of medicines that required addressing.

Medicines were not consistently managed safely. People told us they received their medicines on time and visiting relatives felt assured that care staff managed their relative's medicines well. Some people had been prescribed medicines on an 'as and when needed' basis for example pain relieving medicines or to relieve the symptoms of anxiety. These medicines should only be offered to people under specific circumstances and when specific symptoms are exhibited. Good practice is that staff should be provided with specific guidance as to what these circumstances and symptoms are, the steps they should take before giving the medicine, and for how long the medicines should be administered before they contact the prescriber for further advice. However, this guidance was not always in place for staff to follow, and the reason why some of these medicines had been administered to people had not always been recorded on the Medication Administration Records (MAR). In addition to this the codes that staff had entered on the MAR to indicate whether medicines had been given or not were not always being used accurately. Therefore the provider was not able to monitor the effectiveness of these medicines.

The majority of medicines were received in blisters which contained most of the medicines each person had been prescribed for set times of the day. We did not identify any problems in relation to the recording, administration or stocks of these medicines. However, the balance of the quantity of medicines of 'as and when needed' medicines in stock had not been entered on the MAR. Therefore it was difficult for staff to check whether the stocks of medicines were correct. We completed a spot check on some medicines and found that some did not balance with the amount that had been received, less the amount that was recorded as having been administered. Therefore, the provider could not be assured whether or not these medicines had been administered to people or not.

Medicines were stored securely. However, the temperature of the room that the medicines were stored in had not been recorded consistently and no temperatures had been recorded during the hottest months of the year. In addition to this no action was recorded as being taken when the temperature reading had exceeded the recommended maximum temperature. Therefore the provider could not be assured the temperature medicines had been stored at had not affected the effectiveness of the medicines.

The provider had not ensured the administration and management of medicines was always safe. This is a breach on Regulation 12 of the Health and Social Care Act 2014.

People who needed their medicines at specific times of day received them on time and were administered staff were trained to do so. Medicines were not left unattended at any time and staff did not sign (MAR) charts until medicines had been taken by the person.

Systems were in place to protect people from abuse and keep them free from harm. Staff had received

training in safeguarding adults at risk and were knowledgeable in recognising signs of abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would definitely speak to the manager if either a staff member or a visitor was abusive". Another staff member said, "I haven't worked here very long but I've done training. All the staff seem very caring".

People were supported to be safe without restricting their freedom. One staff member told us, "We let people live their lives here". Another staff member said, "If someone wants to do their own thing, like go out, we don't stop them". Our observations confirmed this. On our arrival, we noted one person leaving the service to run an errand and staff told us one person sometimes took the train up to London. They commented, "They know the risks but it's their choice they have the capacity to understand the risk they are taking". We noted several other people at the service lived with a high degree of independence. They spent the day doings things as and when they pleased. For example, one person chose to help staff by clearing their own tray after meals. Another person's falls risk assessment stated, 'allow to take risks'. However, staff did intervene where appropriate. We were told one person persistently smoked in their room.

People had access to equipment they needed to promote their independence such as wheelchairs, walking frames and stair lifts which enabled people to move around the service without support from staff. Staff had a good understanding of risk assessment and a good knowledge of the people they were caring for. Care plans contained a wide variety of relevant and up to date risk assessments, for example people had been assessed as to whether they were at risk of malnutrition and developing pressure areas. Where risks had been identified appropriate measures had been put in place to mitigate those risks and reduce the risks of harm. For example pressure relieving equipment had been provided. Falls risks assessments had also been completed and measures were in place to reduce the risks of falling for example, making sure people wore the right footwear and people had their walking frames at hand. Where needed referrals had been made for further advice from health care professionals to establish whether there were any underlying health care conditions that may be causing a person to fall.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) and checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including interview notes and copies of identification documents, such as passports in staff files.

There were sufficient numbers of suitably qualified staff to deliver safe care. Staffing levels were consistent, with the registered manager, a lead senior carer and two carers on duty during the day. There were also administrative, domestic, kitchen and maintenance staff on duty and two care staff on night duty. The provider made use of both existing staff and agency staff to cover vacant shifts. The registered manager told us and records confirmed that extra staff were also used for events such as people needing an escort to hospital appointments. Staff told us staffing levels were sufficient to care for people safely. One staff member commented, "I would say there are enough staff around and we do get the chance to speak to people in the afternoons". Another staff member told us, "I've not been here long but I've seen staff spend time with residents. I've got to know most of them". One person told us, "If I press the bell they come quick as they know I keep my eye out for others on my floor".

There were processes in place for regular checks to be undertaken in relation to the safety of the premises and equipment. Portable electrical appliances were tested annually to check they were safe to use. Fire fighting equipment had been serviced regularly and people were aware of the need to evacuate the building in case of fire. The gas safety and insurance certificates were up to date and measures were in place to reduce the risk of legionella. The premises were not purpose built and the layout was such as to present

significant difficulties in evacuating people in the event of an emergency. However, Personal Emergency Evacuation Plans (PEEP) had been devised for each person, with clear instructions regarding how people could be safely evacuated from the building.

Good

Is the service effective?

Our findings

People and their relatives told us they felt well cared for by competent staff. They told us they were supported to access healthcare support when needed and enjoyed the food provided. One person told us they were happy with all the staff but felt a particular member of staff was, "Very efficient". Another person told us they received the support from staff that they needed and commented, "(Staff members' name) knows what I like and knows what I need".

Staff had the training and skills they needed to meet people's needs. The provider had policies and procedures in place to ensure that staff completed an induction which included shadowing experienced members of staff and familiarising themselves with the providers policies and procedures prior to working unsupervised. The registered manager explained that the provider also required all new staff to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It is designed to give confidence that workers have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Records confirmed that the majority of staff had completed or were working towards obtaining this certificate or its equivalent. One staff member told us, "I had training and was given an induction. I never felt I couldn't ask somebody if I was stuck".

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff had completed training in subjects the provider considered to be mandatory such as infection control, health and safety, moving and handling people, fire awareness and safeguarding vulnerable adults. Staff were also given the opportunity to undertake more specialised training in order to meet the needs of people they were caring for. Most staff had also undergone training to meet the needs of people living with dementia and some staff had also attended training provided by the Dementia In Reach Team. One staff member said, "If it's needed, we will do the training".

The provider had systems in place for staff to receive one to one supervision with their line manager at which they could discuss in private their personal and professional development and for an annual appraisal of their performance to take place. Staff felt supported by their senior managers and their colleagues. Staff told us they had received recent, formal supervision. One staff member said, "The manager is really good and they will always listen".

People were supported to have sufficient to eat and drink and to maintain a healthy diet. People's weight was monitored and referrals were made to relevant health care professionals when needed for example, some people with swallowing difficulties had been assessed as at risk of choking and had been referred to a Speech and Language Therapist (SALT). Some of these people required their food to be prepared in a specific way for example for their food to be cut up into small pieces or to be soft textured. One person was required to eat a fibre free diet and another person preferred to eat a vegetarian diet. People had been asked about their likes and dislikes in relation to food and these had been recorded. The chef had access to this information and saw that people were provided with meals that met their dietary needs and preferences. People's comments on the food provided ranged included, "I don't like lunch I normally have

baked potato or soup", "There's one choice of main meal but if you don't like it you can have something else", "I have no complaints about the food, they'll always find you something" and "The food is very good, if by chance you don't like it you can always have something else. Today I had veggie burger and salad".

People had access to drinks. There was a cold water dispenser in the communal lounge and each person had a jug of water and drinking glasses in their room. One person who could not lift a jug had been provided with a smaller bottle of cold water which they could manage. We heard staff offering people hot and cold drinks throughout the day and encouraging people to drink and saw one person enjoying a sherry with their lunch.

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.

The registered manager told us applications to deprive some people living at the service of their liberty in specific circumstances had been submitted to the local authority for their approval and records confirmed this. They demonstrated a firm understanding of the MCA. Staff had undertaken recent training in this area and had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Records confirmed that mental capacity assessments had been undertaken appropriately. For example one person's medicines management care plan identified they were prone to hiding their medicines if not closely supervised. A mental capacity assessment had been completed to ensure the person understood the risks of not taking medicines, which they did. Staff had subsequently spoken to the person about the situation. Although no reason for person doing this was established, the person agreed to a period of close supervision with medicines. It was also explained there was no need to hide medicines when it was within their rights to simply refuse them.

Staff told us and we observed they gained consent from people before supporting them and delivering care. We were told the principle of assuming people had capacity to make their own decisions was followed. Staff told us that everyone was able to make their own day to day decisions and that if they were not able to make a decision for example, whether to receive medical treatment then their family members and the persons social worker would be consulted. One staff member told us, "We always assume people can make decisions for themselves. We wouldn't want to take that away". Consent had also been sought and obtained from people in areas such as information sharing and photography for identification purposes.

People's health care needs were met. People told us they were supported to see their GP and dentist when needed. A referral had been made for people to see a Speech and Language Therapist (SALT) when needed and input from other health care professionals such as psychology, physiotherapists and tissue viability nurses had also been sought. Records detailed when health care professionals had been contacted for advice and when people had attended healthcare and hospital appointments. One person told us, "They ring through to the doctors for an appointment for me". A family member of another person told us they had

asked for a doctors to be called which they said was done, "promptly". A third person told us, "(Staff members name) makes all my appointments for me".

Good

Is the service caring?

Our findings

Staff knew people well and demonstrated understanding of the preferences and personalities of the people they supported, and with whom caring relationships had been developed. People were at ease with staff and each other and jokes were shared in the many conversations we heard throughout the day. One person told us, "The care staff are very good, I'm quite content here". Staff communicated with people effectively in a warm, friendly and sensitive manner that took account of their needs and understanding. A staff member told us the reason they worked at the service was because of the relationships they had built with people.

We observed staff treated people with kindness and understanding and staff consistently took care to ask permission before intervening or assisting. Interactions and conversations between staff and people were positive. People told us they felt staff were kind and we observed staff showing patience and understanding, for example by giving people who struggled to communicate verbally time to express what they wanted to say. Staff made time to talk to people whilst going about their day to day work. It was clear staff knew people well but equally people were familiar with staff and happy to approach them if they had concerns or worries.

It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose for example, we observed one person who had recently moved into the service walked into the kitchen saying they were lost. Staff stepped in and acted quickly to offer them reassurance, redirect and re orientate them.

People's privacy and dignity were respected and promoted. Staff told us about how they protected people's dignity such as when helping them with personal care. They demonstrated they had a good understanding of the importance of maintaining people's dignity and treating people with respect. One member of staff told us, "We always close the doors when we are supporting people with their personal care". Our observations confirmed that doors were kept shut when personal care was being delivered and that staff knocked on people's doors and waited for a response before entering their rooms.

People had choice and control over their own lives. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. They told us they that they were free to do very much what they wanted throughout the day. They told us they were able to get up and go to bed when they wanted to and were not woken in the mornings. No one ever felt rushed by staff and all told us they were able to take showers, with assistance, as often as they wanted. One person told us "I'm allowed out when I like". A staff member told us, "We allow people to live their own lives. This is their home, not ours".

People were encouraged to remain independent and do as much as they could for themselves. When we arrived we saw one person taking their breakfast tray to the kitchen and other people were helping themselves from the water dispenser. We saw other people using the stair lifts without support of staff and turning on the TV to watch programs of their choice.

Visitors were welcomed and there were no restrictions on visiting times. One person told us, "My daughter comes whenever she pleases and stays as long as she likes". Another person told us, "My family visit and get on well with the staff. They stay as long as they want to". Visiting relatives told us they were happy with the care their loved one was receiving.

We looked at people's care plans and daily records in order to ascertain how staff involved people and their families with their care as much as possible. They contained extensive life history sections. It was possible to 'see the person' in these care plans and for staff to access information that would help build meaningful relationships. People or their representatives had regular and formal involvement in on-going care planning. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately.

Some people chose to stay in their bedrooms, others in the communal areas. Each person had their own room which had been personalised with their belongings and memorabilia. For example, people had family photographs on display and were able to bring their own furniture.

Information about people was stored securely and staff made sure that doors were shut when we were discussing the needs of individuals.

Good

Is the service responsive?

Our findings

At the last inspection people had mixed views about the opportunities for social engagement and interactions. People had spoken positively about the trips out but felt more activities could be on offer. Although staff had told us that they spent time with people and people did participate in activities on a daily basis care records did not reflect this. We therefore identified these issues as areas of practice that needed improvement. At this inspection we found improvements had been made.

Feedback from some people who could not go out independently was that they still did not have enough to do and did not get the opportunity to go out as often as they would like. The registered manager and staff told us most people did engage in an activity of some sort every day. People were offered the opportunity to go out with staff or with a local organisation that organised bus trips for older people, on a regular basis. But when it came to the day of the outing people often declined the offer. They also explained that due to the deterioration of some people's memories they could not always remember how they had spent their time and could not always recall the activities they had participated in. Records confirmed that some of these people did take part in arranged activities on a regular basis.

At the last inspection there was no activity timetable in place to inform people of the activities on offer. At this inspection this had been addressed and there was an activity timetable informing people what activities were available. For the month of September 2016 this comprised of an hours activity each day at 3.45pm such as board games, word search, general chat, jam tart making, puzzles or sing-alongs. There had also been a visit from a local church and a local photographer who was taking photographs of people and staff in order to compile a 'Conifer Lodge' calendar for 2017. The registered manager told us that in addition to this, entertainers, such as singers or musicians, came to the service approximately once a month. They also told us there had been two trips out this year on the provider's mini bus. One person commented, "We've had a lovely trip in the mini bus to Stammer Park but we didn't have a garden party this year because of a problem with the garden. We're having a Halloween party instead". Staff told us they reminded people each day what the activity was and asked them if they would like to join in but some people preferred to occupy themselves.

Some people confirmed they preferred to watch television in their own rooms or in the smoking room where some people chose to socialise. Other people who were able to go out without support from staff told us they liked to go out to visit friends and family, go shopping or go to the local pub and could do so as and when they pleased. One person commented, "There are activities but not on a regular day, quizzes, baking, board games. I don't join in because I'm not interested". Another person told us they had brought their pet budgies with them which were kept in the lounge and people commented that they liked watching them and listening to them. There was also a piano which one person enjoyed playing before lunch.

The registered manager told us staff were working with people to put together an individual activity profile for each person and had sought advice and guidance from the local Dementia In reach Team in relation to this. They had asked people if they would like to compile 'memory boxes' in which to keep photographs and other memorabilia to remind them of their past. Most people had declined this offer but people who wanted

to do this had been supported by staff to do so. Records showed that activities profiles had been compiled for some people. These included sensory activities that people enjoyed such as 'I like the feel of a nice warm cup of tea in my hands, I like the sound of people talking' anther persons stated 'I like to watch TV I have the subtitles on so I can ensure I don't miss anything they are saying' and 'I enjoy the sounds of the birds chirping and I love the sound of the staff laughing'. The registered manager told us these would be completed for everyone and incorporated into their care plans.

People were able to visit the service and have their needs assessed before they made a decision about whether they wanted to move in. People's initial assessments had been used as a basis on which to formulate a care plan. It was evident from the information they contained that individuals and or their relevant family members had been consulted. Sections of the care plans were detailed and provided specific guidance for staff to follow when supporting people with their individual needs. These were reviewed and updated monthly and signed by staff and where possible the person.

People's care plans contained information about people's care needs and actions required in order to meet them. People's choices and preferences were also documented. The care plans contained information about people's care needs and actions required in order to provide safe and effective care. For example, we noted one person suffered from chronic anxiety and occasional challenging behaviour. Plans contained information for staff on how to manage situations arising from this. For example, possible triggers to anxiety and aggression had been identified and appropriate 'de-escalation' techniques to be used in order to keep the person and others safe. The provider had also referred the person to the Older People's Community Mental Health Team for specialist support.

Staff knew people well and had a good understanding of their care and support needs. There were processes in place to ensure staff had up to date information about people's changing needs. Staff told us and we observed they were informed about people's changing day to day needs at the handover at the start of each shift. The off going team leaders provided information on any issues or incidents that had taken place. They also provided information on any appointments that were planned. Staff told us there was always a team leader or member of the management team on duty they could go to for advice or provide them with updates on their return from a leave of absence from work.

There were systems in place to respond to complaints. People were provided with information about how to make a complaint when they moved into the service and the complaints procedure was on display in the reception area of the service. Complaints received by the provider had been recorded and responded to appropriately. People told us they would speak with a member of the care staff team if they had any concerns or wanted to make a complaint. One person remarked about making a complaint about a light fitting in their room as the carers kept hitting their heads on it when by the bed. This was removed which was what they wanted. Another person told us they had no reservations about raising concerns and commented, "They listen to me".

Requires Improvement

Is the service well-led?

Our findings

Staff told us they felt supported by management and each other and that management were approachable. We observed staff coming to speak with management about a range of issues during the day for example to ask to speak to the registered manager in private or to say hello and pass the time of day. People spoke highly of the registered manager and told us they would speak to them or the care staff if they had any concerns. One person commented, "I would go to (registered managers name), if I had any concerns she is wonderful, so kind with everybody". Staff also spoke highly of the registered manager and told us they were 'extremely supportive' and 'always available for advice'. Feedback the registered manager had received about the service in 2016 included the following comments 'I think the standard of care and attitude of the staff is excellent. A very high quality staff, friendly, open and caring', 'I always have a good experience when visiting Conifer Lodge. The staff are dedicated and committed to client patient care and have an excellent relationship.' And 'This is just to say a huge thank you for all the kindness and care you give to our loved one. She is so happy at Conifer Lodge and we much appreciate this'. Despite the high praise for service provided by the registered manager and staff team, there were areas of practice identified as needing to improve at the last inspection that had not yet been fully addressed.

At the last inspection there were various systems in place to monitor and analyse the quality of the service provided but there were no mechanisms in place to monitor, analyse and review the effectiveness of care plans. This was an area of practice we identified as needing to improve. At this inspection the provider had introduced monthly care plan audits however, these had not been consistently completed and those that had been completed were ineffective. The audits asked questions such as whether care plans were comprehensive, whether risk assessments were relevant and whether people and their families were involved in the process. The answers to these questions were vague and did not give a meaningful overview of the care provided. For example, the audit asked if outside professionals were involved in people's care. One person was in receipt of such a service however, the audit stated' District Nurses'. It gave no indication of why they were involved or if the intervention had been recorded appropriately. In addition to this audits did not revisit issues arising from the previous audit for example; the August audit did not indicate whether the sections of care plans that had been identified as missing as part of the last audit, completed in May, were now in place. When we checked one persons' care plan the missing sections had not been implemented. Therefore the provider could not be assured the care plans were up to date and accurately reflected people's care needs.

At the last inspection the ground in the garden was uneven and needing repairing so people could use it safely. At that time the registered manager advised they had put forward requests to the provider for this work to be completed, but had not yet heard back from them and we identified this as an area of practice that needed improvement. At this inspection people told us they were still not able to use that part of the garden because the repairs had not been made. Subsequent to the inspection the provider informed us that two other areas of garden space, one with grass and flower beds and another with a paved area, were available for people to use throughout the summer months. The 'Manager's Monthly Health and Safety Inspection Checklist', which looked at areas such as the services' state of upkeep, had regularly identified areas of refurbishment needed; for example stained or worn carpets. We also saw that the flooring and tiling

in some of the bathrooms were in need of updating and repair and paintwork was chipped throughout the service. The registered manager told us they sent the audits to the provider but no improvement plan had been forthcoming and they could not show us any schedule for this repair or of any on-going improvements and refurbishment work.

At the last inspection we raised concerns that a systematic approach to determining staffing levels was not in place and identified this as area of practice that needed improvement. At this inspection the provider had introduced a protocol for assessing people's dependency levels which in turn indicated when the staffing levels needed to be reviewed, however the provider had not ensured they had followed this. The provider's protocol stated the dependency rating would be completed at pre admission to determine the level of care and support the person required and that the person should be re assessed on a weekly basis for the first four weeks. The registered manager told us they had not completed dependency forms for the last three months despite the fact that one person had only recently moved in. Following the inspection the registered manager sent us an up to date copy of the dependency profiles for each person using the service. The provider's protocol stated that a review of the staffing levels would be completed when the total dependency scores of the people living at the service reached a certain figure. The information they sent us showed that this figure had been exceeded; however there was no evidence to show that the provider had conducted a review of the staffing levels. Therefore the provider could not be assured that the staffing levels were still sufficient to provide people with care that was responsive to their needs.

The provider had systems in place to audit the medicines and medication administration records, however these had not been consistently completed and those that had not always identified areas of improvement. These audits were scheduled to be completed monthly however we were told only three had been completed this year. The last medication audit completed in September 2016 indicated that guidance for when 'as and when' needed medicines were in place and kept in people's care plans. However we identified this was not the case. The audit had also failed to identify that the MAR had not been completed accurately therefore the audit was not effective.

The provider had not ensured the processes they had in place to monitor quality and identify areas for improvement were effectively implemented. This is a breach of Regulation 17 of the Health and Care Act Regulations 2014.

Some of the shortfalls in the 'Manager's Monthly Health and Safety Inspection Checklist' which had been identified as needing to improve at the last inspection had been completed. Trees in the garden had been cut back and chairs in the smoking room had been replaced.

The provider had a system to monitor the effectiveness of falls management. These were tightly focused around issues such as the reasons for falls, the types of injuries, if any, sustained and actions taken by staff. The total numbers of falls and where they occurred was also recorded. These audits gave a clear indication of why falls were happening and what was being done to reduce the risk of reoccurrence, by whom and by when. Information from accidents forms were collated by the registered manager. They were then analysed to identify any themes or trends which would help inform them of strategies they could use to reduce the risk of reoccurrence.

The registered manager told us their focus was supporting people to live the lives of their choice and staff echoed this view. One staff told us, "People can do what they want". We observed this happened in practice and saw people coming and going throughout the day going about their own business.

People were given the opportunity to give their views on the service. Residents meetings took place every

three months at which people could discuss any matters arising and give their views. At the last meeting in September information was shared with people about various issues including dates for the forthcoming entertainment and the names of new staff members. People were also asked if they had any complaints or any other business they wanted to discuss. One person confirmed they had attended the last meeting and told us, "They happen every quarter they get things done, they're changing the TV's in the residents' rooms". The registered manager explained people were also provided with details of how to provide feedback to a third party about their experiences of the service. We saw people could provide their feedback by completing and posting a pre-paid questionnaire or on line. We saw that not many people had taken up of the opportunity to complete the questionnaires themselves, but that the registered manager had added the feedback they had received from people by way of thank you cards to the web site. Subsequent to the inspection the provider informed us that a majority of the feedback on the website consisted of questionnaires and that there had been a fault on the website which had shown that the feedback was taken from thank-you cards. The provider planned to contact the website's designers to ensure that this was corrected. The feedback on the web site was overwhelmingly positive and to date there had been no issues arising from the feedback that required them to take any corrective action.

The registered manager had informed the commission of notifiable events at the service by completing statutory notifications as required by. They were aware of the Duty of Candour regulation. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided. Records showed that they had kept people's relatives informed of any accidents and incidents people had been involved in. The last inspection report and rating was on display at the service and on the provider's website as is required by law.

The registered manager told us they kept up to date with current good practice guidelines by attending managers meetings with the area manager and mangers of the providers' other services at which they shared learning and discussed new developments in care.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12(1)(2)(g) The registered person had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the processes they had in place to monitor quality and identify areas for improvement were effectively implemented.