Care Quality Commission

Ideal Carehomes (Number One) Limited

Greenacres

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 and 12 June 2017 and was unannounced on the first day and announced on the second day. The service was first registered on 1 February 2016 and this was the first inspection under the new name of the registered provider.

Greenacres provides accommodation and personal care for up to 64 people, including people living with dementia. Accommodation is arranged over two floors. There are two units on each floor. Each unit has single bedrooms which have en-suite facilities. There are communal bathrooms throughout the home. Each unit has an open plan communal lounge and dining room.

The service did not have 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. The manager had applied to register with CQC and their application had not been finalised at the time of this inspection.

We found adequate numbers of staff were not deployed to meet people's assessed needs. This meant people's needs were not always met in a timely manner.

People told us they felt safe. Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Effective recruitment and selection processes were in place and medicines were managed in a safe way for people.

Staff had received an induction, supervision, appraisal and role specific training. This ensured staff had the knowledge and skills to support people who used the service.

People's mental capacity was not always considered when decisions needed to be made for example where people needed to consent to the administration of their medicines. This meant people's rights were not always protected in line with legislation and guidance.

People's nutritional needs were met and they had access to a range of health professionals to maintain their health and well-being.

Staff were caring and supported people in a way that maintained their dignity and privacy. People were supported to be as independent as possible throughout their daily lives.

Individual needs were assessed and met through the development of detailed personalised care plans.

People and their representatives were involved in care planning and reviews. People's needs were reviewed as soon as their situation changed.

Some people engaged in activities; however the service relied on care staff to deliver these activities, which meant dedicated time was not always available.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

The registered provider had an overview of the service. They audited and monitored the service to ensure people's needs were met but this system had not identified and addressed some of the concerns we found.

The manager knew the needs of people who used the service and people and staff were positive about her input in to the service.

The manager had taken action to improve the quality of the service. People who used the service, their representatives and staff were asked for their views about the service and they were acted on.

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.

People's needs were not always met in a timely manner as sufficient numbers of staff were not deployed.

Staff had a good understanding of how to safeguard people from abuse.

Risks assessments were individual to people's needs and provided direction for staff.

Recruitment procedures were robust and medicines were managed in a safe way for people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was not always considered when decisions needed to be made.

Staff had received training to enable them to provide support to people who lived at Greenacres.

People were supported to eat a balanced diet and had access to external health care professionals.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

People's care plans contained sufficient and relevant information to provide person centred care and support.

Most people had access to activities in line with their tastes and interests.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider had not identified and addressed some of the concerns we found.

People and staff were positive about the manager, who was visible within the service and knew the needs of people using the service.

The culture was positive, person centred, open and inclusive.

Care Quality Commission

Greenacres

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 7 and 12 June 2017 and was unannounced on the first day and announced on the second day. The inspection was conducted by two adult social care inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector conducted the second day of the inspection.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team and commissioners. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

Some people who used the service communicated non-verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time with them observing the support people received. We spoke with 12 people who used the service and four relatives. We spoke with seven care staff, two senior care staff, the deputy manager, the front of house manager, the cook, the manager and the regional director. We looked in the bedrooms of 10 people who used the service with permission.

During our inspection we spent time looking at eight people's care and support records. We also looked at three records relating to staff recruitment, four training records, incident records, maintenance records, feedback from people and a selection of audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Greenacres and the relatives we spoke with told us they felt confident their relation was safe. One person said, "I don't have to wait too long when I need help." Another person told us, "I'm quite safe here. Sometimes I have to shout when I fall. They come reasonably quickly." One person told us they wanted to retire to bed around 9pm the previous evening, but staff had not been available to support them until around midnight.

Staff told us there were not enough staff on duty on the units where people were more dependent. One staff member said, "Residents are needing more help and it's hard to deliver care to all. There is a floating senior on each floor. They can't help much because they are wanted on the other unit. The management say that they are there to help. It's not always possible." Another staff member said, "The dependency levels of these residents have risen and it's not possible for us to give all the residents the care they deserve. Of course we can keep them safe but not do the best for them and offer them a more fulfilled life." One staff member said, "If a person needs two for personal care we have to ring round to see if anyone can leave the other unit." A further staff member said, "The dependency levels of the residents have gone up and the staffing does not show that." Another staff member said, "There are not enough. If you are showering someone and a pressure mat goes off you can't leave them." One staff member said if lots of people wanted a bath at the same time, it could be hard to meet needs, but overall there were enough staff.

The manager told us a dependency tool was used to assess people's dependency levels and allocate staffing within the service. We saw each person's dependency level was assessed every month and staffing hours were allocated accordingly. At the time of this inspection 59 people were using the service.

The regional director told us the registered provider was reducing the dependency levels of people they accepted at the service; however the dependency level assessment had fluctuated from 192 care hours needed per week in February to 236 in March and 226 in May 2017. The regional director told us they had increased day time staffing hours by 12 hours a week to reflect the dependency levels.

We looked at historic rotas and saw eight care staff were on duty during the day, plus one floating senior support worker on each of two floors and a deputy manager. The manager said the floating seniors would spend most of their time on the two dementia units due to levels of risk and would also administer medicines on both units on their floor. On two occasions we saw nine care staff were on duty to support people with occasional outings or with life story work. On 29 and 30 May 2017 seven care staff were on duty in the morning. The manager told us this was due to unexpected changes in staff availability and on these occasions senior carers would stay on the dementia units to support staff and the deputy manager would administer medicines. A deputy manager was on duty every day and a care manager was also usually on duty, but this post was vacant. The manager usually worked Monday to Friday.

At night time there were four care staff on duty and a night care manager. There was some overlap in staff at key times such as 7am to 8am and 8pm until 10pm to enable personal care to be provided to people when rising or retiring for the day.

A call system was in place around the building which people could use to summon staff assistance if needed. For some people this was linked to a sensor mat on the bedroom floor or bed to alert staff to their movement, for example if a person was at risk of falls. During the first day of our inspection we found call bells were not responded to in a timely manner. For example, we heard one person's alarm sounding for 10 minutes before staff responded after being prompted by an inspector.

After lunch we observed one person waited 25 minutes to be transferred from their wheelchair into a comfortable chair. This meant their needs were not met promptly and they received insufficient support.

At 4.15pm when tea was being served we found staff did not respond to the call bell from one person's room until alerted to this by an inspector. This was a person who spent their days in their room, had complex health conditions and had told staff earlier they felt "shocking."

This meant the registered provider did not deploy sufficient numbers of staff to meet people's assessed needs. The above issues were a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered provider had recently recruited new staff to the service and they were awaiting pre-employment checks. The registered provider had their own bank of staff to cover for absence and asked permanent staff to do extra shifts in the event of sickness. Regular agency staff were also used. This meant people were normally supported and cared for by staff who knew them well.

We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and CQC had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One staff member said, "If I saw bad practice I would report it to the manager and they would act on it. If it was the manager I would ring (name of regional director). If not CQC." We saw information around the building about reporting abuse and whistleblowing.

Systems were in place to manage and reduce risks to people. In people's care records we saw comprehensive risk assessments to mitigate risk in areas including mobility, choking, physical health, hygiene, falls, finances, medication. We saw these assessments were reviewed regularly, signed and up to date. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence. The manager had requested additional training for staff on preventing and managing falls from the local falls prevention service, which had been delivered in May 2017. This showed they had taken action to deliver safe care and reduce risks to people.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded in detail and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety of the service.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. For example, the provider ensured references had been obtained and Disclosure and Barring

Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed staff had been properly checked to make sure they were suitable and safe to work with people.

We found appropriate arrangements were in place for the management of medicines. The manager told us senior staff at the home completed training in safe administration of medicines and we saw certificates to confirm this. Senior staff told us they completed training in medicines administration and then completed three medicines rounds with support before being signed off as competent. We saw staff competence in giving medicines had been assessed and plans were in place to continue to assess this regularly. This meant people received their medicines from people who had the appropriate knowledge and skills.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. People's medicines were stored safely in a secure medicines trolley and stored in secure medicines room on each floor.

We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered with the exception of two Paracetamol. The senior on duty said it may have been administered but not signed for by staff and they would follow it up. Staff maintained records for medicines which were not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. We saw a stock check was completed daily and administration of medicines was checked and signed by two members of staff. This demonstrated the home had good medicines governance.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded.

Creams and ointments were dated upon opening and found to be in date and body maps were in place to guide staff as to where to administer creams. Most people's records for the application of topical creams were administered as prescribed, however one person's cream stated apply three times a day and the record was signed twice a day. The manager said they would follow this up with staff.

Medicines care plans contained information about medicines and how the person liked to take them, including an individual 'when required' (PRN) medication protocol for the person. One person didn't have a 'when required' protocol for Paracetamol and the manager told us they would address this, although staff were aware of how and when it should be administered. Having a PRN protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing. Checks had been completed on fire safety equipment and fire safety checks were completed in line with the provider's policy. A series of risk assessments were in place relating to health and safety. We found the emergency lights at the rear emergency exit to the home had been awaiting repair for some time, although the maintenance person had reported this regularly to the registered provider. The manager followed this up with the registered provider on the day of our inspection.

People had a detailed personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. A fire training sheet was signed by staff

and fire drills occurred regularly. The staff we spoke with knew what to do in the event of a fire or if the building needed to be evacuated. This showed us the home had plans in place in the event of an emergency situation.

The service was clean and odour free and personal protective equipment (PPE) was available for staff to use. This meant effective measures were in place to protect people from the spread of infections.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they were confident the staff team at Greenacres could meet their relation's needs.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

Staff at the service had completed training and had an understanding of the MCA 2005. One staff member said, "It is about what is in the best interests for the person if they can't make a decision."

We asked the manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. We saw 35 people were subject to DoLS authorisations with no conditions or were awaiting assessment. 24 further people had been assessed as having mental capacity to decide to live at the home.

We saw in the care records we sampled mental capacity assessments and best interest decisions had been completed in relation to restrictions such as sensor mats, bed rails, and coming to live at the home. No mental capacity assessments and best interest decisions had been recorded in relation to the administration of medicines for anyone using the service who lacked mental capacity. We also found where mental capacity assessments had been completed for some people, no best interest discussion had been recorded to show the person's representative had been consulted and the decision that was made on the person's behalf was the least restrictive and in their best interests. This meant the rights of people who used the service were not always protected in line with the requirements of the Mental Capacity Act 2005.

In two of the care records we sampled consent to the care plan was not completed or signed. Evidence that some people's representatives held lasting power of attorney to make some decision on their behalf was not always available.

The above issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection the manager had completed mental capacity assessments with people

who required medicines to be administered on their behalf and was in the process of consulting the relevant people. The manager was also taking steps to ensure evidence was available where a person's representative held Lasting Power of Attorney giving them legal authority to act on their behalf.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. We asked five staff what support new employees received. They told us they completed initial induction training and then shadowed a more experienced staff member for around three shifts as well as completing further training, before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. One staff member said, "I spent the first two weeks training and shadowing. The last two weeks have been working on units. I have been on this unit for three days and it's really good." This demonstrated new employees were supported in their role.

We looked at the training records for four staff and saw training included infection prevention and control, emergency aid, food hygiene, moving and handling, dementia awareness, The Mental Capacity Act and DoLS, and safeguarding adults. We saw from the training matrix almost all training was up to date and further training was planned onto the rota. The new manager had booked all staff on moving and handling training to ensure this could be refreshed at the same time every year and letters had been given to staff to ensure they were aware of their responsibilities to update their mandatory on line training. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt appropriately supported by managers and they had supervision every few months, an annual appraisal and regular staff meetings. The manager had completed a supervision and appraisal planner and we saw regular supervision and appraisal was completed with most staff and where there were gaps the manager had ensured more regular supervision was taking place. Staff supervisions covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. This showed staff were receiving regular management supervision to monitor their performance and development needs.

One person said, "There is always a choice of meals. I don't like mushroom and if they give me I tell them and no problem they sort that out." Another person said, "Food, for a place like this can't complain. I like what they give me." And a further person said, "The food is good and I get a choice. I change my mind sometimes. Staff get me something I like."

Meals were planned around the tastes and preferences of people who used the service. Pictorial menus were on display with a choice of two meals and two desserts. We heard staff offering people a choice of meal and drink and we saw they received the meal and drink of their choosing.

The tables were attractively set and music was playing in the background. Contrasting crockery had been ordered but was not yet in place to support people with visual impairments to locate their plate and promote independence. We saw staff supported and encouraged people to eat and drink. Interactions between staff and people were friendly, respectful and supportive.

The cook had a file in the kitchen with special dietary requirements and tastes and this information was also available on each unit to guide staff where food was being served. We saw some people helped themselves to a drink, and snacks and drinks were offered to people throughout the day. Following feedback from a recent residents' survey the manager met with kitchen staff and residents and more toast and teacakes were

offered at supper time to fill the gap between tea and breakfast. The cook told us they always met residents when they first move into the home to find out their likes and dislikes and to discuss any specific dietary requirements.

We saw the individual dietary requirements of people were catered for, for example; some people had meals of specific consistency following advice from the speech and language therapy team. Meals were recorded in people's daily records. This included a record of food consumed, including where food intake was declined and details of the food eaten. People were weighed monthly or weekly if needed to keep an overview of any changes in their weight. We saw the manager kept an audit of weights to look for any patterns or changes and contacted the GP if action was required. We saw from meeting records senior staff were reminded to encourage people to take fortified milkshakes and snacks throughout the day. This showed the service ensured people's nutritional needs were monitored and action taken if required.

People had access to external health professionals as the need arose. We discussed the way in which one person's health condition was managed with the manager and they requested a protocol from the nurse and GP to ensure they were acting in line with best practice in supporting the person with their condition. Staff told us systems were in place to make sure people's healthcare needs were met. Staff said people attended healthcare appointments and we saw from people's care records a range of health professionals were involved. This had included GP's, psychiatrists, community nurses, chiropodists and dentists, speech and language therapy and physiotherapists and the falls team. This showed people who used the service received additional support when required for meeting their care and treatment needs.

People's individual needs were met by the adaptation, design and decoration of the service. We saw the home was homely and spacious and comfortably furnished. There were pictures and photographs in the communal areas and the lounges were arranged in a way that encouraged social interaction. Bedroom doors were numbered along with a photograph of the person if they wished, to aid orientation. People had access to the well-kept secure gardens with seating. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring. One person said, "Very pleased to be here. Staff are kind and good to me. Lovely room always kept clean." Another person said, "I am happy here. Staff are helpful." Another said, "Staff are very nice. I am okay here." A further person said "Staff are marvellous, kind and helpful here."

People who used the service told us they liked the staff and we saw there were warm and positive relationships between people. Staff we spoke with enjoyed working at Greenacres and supporting people who used the service. One staff member said, "It is rewarding. You have helped people to achieve something, even if it is only doing their buttons up and it takes them a week to get to that stage." Another said, "I love it. I like spending time with people." And another staff member said, "I treat someone as I want to be treated. As if I was looking after a family member."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities. They used this knowledge to engage people in meaningful ways, for example, by engaging them in conversations about activities or playing music they knew the person liked. We saw people laughing and smiling with staff.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw one person was reassured in a kind and supportive way when they were feeling upset. Staff used appropriate touch and spoke kindly to the person offering them a cup of tea and spending time with them. We observed staff placing a cushion to support a person who was slumped in a chair to improve their comfort.

People were supported to make choices and decisions about their daily lives. People told us they had a choice of meals, what time to get up or go to bed, clothing, activities or when to have a bath. Staff used speech, gestures, and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or food to support them to make every day decisions if verbal communication was limited. One staff member said, "They often say they want the last thing you offered so I show them the options to help them choose. They don't always know the words."

We heard staff give good explanations to people to help them understand how they were being supported. We saw they waited patiently for people to respond and people were not rushed in their interactions, although some people did have to wait for support to transfer.

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style.

We saw two people who used the service had their own bedroom door key in order to lock their bedroom door if they wished to do so. Staff knocked and asked permission before entering bedrooms. Staff told us

they kept people covered during personal care and ensured doors were closed. People's private information was respected and records were kept securely in the office and in locked cupboards on each unit.

People's individual rooms were personalised to their taste with personal items, photographs, ornaments, music and bedding they had chosen. Personalising bedrooms helped staff to get to know a person and helped to create a sense of familiarity and make a person feel more comfortable.

People were encouraged to do things for themselves in their daily life. Staff told us some people helped with folding towels and other domestic tasks. One staff member said, "If they can walk let them walk. They need to use their bodies." Care plans detailed what people could do for themselves and areas where they might need support. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

Staff were aware of how to access advocacy services for people if the need arose and some people who used the service had independent mental capacity advocates. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People and their representatives had been consulted regarding end of life plans and wishes and these were recorded. Our review of care plans evidenced there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. This included an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form.

Good

Is the service responsive?

Our findings

Through speaking with people who used the service and relatives we felt confident people's views were taken into account in planning their care. One person told us, "I can have a bath or a shower when I want to, but I have to ask staff to help me. Can't manage myself and they have no problems giving me a bath." Another person said, "I go out into the grounds when care staff are able to take me out. I need help when showering and I have a shower at least once a week."

One relative said, "I am happy with the way staff look after (relative). I am very much involved in the care plans."

One staff member said, "All the residents and relatives are encouraged and they are given the care records if they want to read themselves."

We found care plans were person centred and explained how people liked to be supported. For example, entries in the care plans we looked at included, "likes to listen to jazz and read the paper." This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care. This is important as some of the people who used the service had memory impairments and were not always able to communicate their preferences.

Care plans covered areas such as accessing the community, medication, sleep, physical health, skin integrity, finances, memory and understanding and recreation. People's needs were reviewed as soon as their situation changed. Reviews were held regularly and care plans were evaluated and updated monthly or when needs changed. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage.

Care plans also contained information about how staff would care for people when they exhibited behaviours that may challenge others, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

People told us they were able to access activities in line with their tastes and interests. One person said, "I read, knit and chat to the others. I enjoy outings. They take us out but they need to take us to places where we can sit and rest."

We found activities were provided, but where people stayed in their rooms there was less opportunity for interaction. Staff spoke with good insight into people's personal interests and we saw from activity records some people had taken part in activities both inside and outside the service.

One staff member said, "I think the activities they put on are really good." Another staff member said most people didn't want to engage with activities, but just wanted to listen to music, watch a film or knit. Staff

told us they had tried a herbal tea tasting session with people and some people had enjoyed the sensory experience.

The home did not employ an activity coordinator and the manager said a regional activity champion fed ideas into the home for the home's activity champion to utilise. The front of house manager was currently arranging some activities as part of their role and they had a few hours each day to plan activities, which care staff then delivered. Staff told us they rarely had time to complete activities with people and they thought the home would benefit from a dedicated activity co-coordinator. One staff member said, "You sit down to do an activity with people and the buzzer goes." The front of house manager told us they organised a small local outing every week and one long distance outing each month.

On the first day of our inspection six people went out to an ice-cream parlour for 'Yummy Yorkshire ice-cream' day and people in the home were served a choice of ice-creams on cones in the afternoon. On the second day of our inspection some people were offered pop-corn in the afternoon and watched a film in the lounge. Later we saw one carer tried to engage a person in colouring, however the person preferred to watch them. Musical instruments and table top games had been purchased in response to feedback and to involve people in stimulation and interaction. We saw activities such as carpet Bowles and table top games were available in communal areas and some people looked at picture books and listened to music. One person had a sensory cushion with objects attached and another person was fascinated by the fish tank.

We saw on the notice board Holy Communion was offered to people and some people attended a 'Friend to friend' group locally. A quiet room was available containing books and a piano. We did not see people using this room during our inspection.

The home had begun to hold themed restaurant evenings where families could attend and enjoy a meal with their relative in a 'pop up' restaurant. This meant staff supported people with their social and relationship needs.

People we spoke with told us staff were always approachable and they were able to raise any concerns. One person said, "I don't complain. I talk to staff and sort it out. I have made friends with some of these people and we support each other." Another person said, "I have no complaints. If I am not happy I will talk to the higher management. I haven't needed to." A further person said, "I have a nice clean room and a double bed, can't complain." We saw there was an easy read complaints procedure on display. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the service was well-led. One relative said, "I am happy that (name) has gone out today. (Name) is often reluctant. I visit often and my (relative) is very settled and I would say is looked after well".

Staff we spoke with were positive about the manager and told us the home was well led. Staff said, "We have had lots of managers. (Name of manager) does listen to what we say. Her door is always open." Another staff member said, "Yes it's well led. It's a lovely home." Another said, "The leadership is really good. It's firm but inclusive. (Name of manager) is good at talking to staff. I see her most days." A further staff member said, "Now we have (name of manager) it's well led."

At the time of this inspection the service did not have a registered manager in post. A registered manager was in post from October 2016 until February 2017. The current manager had been working as care manager at the service for several years and had been acting manager since February 2017. They commenced their role as permanent manager in April 2017. They had begun the process of applying to register with the Care Quality Commission in May 2017 and at the time of this inspection their application had not been finalised.

Three deputy managers worked on rotation during the day and a night manager was on duty every night. The care coordinator post had recently been recruited to and pre-employment checks were in process. Two senior carers were on duty on all shifts during the day.

On the first day of our inspection we discussed staff response to call bells with the manager and looked at call bell response times on the computer. Some of the call bells that we heard were not recorded on the call bell response time recording system and the manager found the system for recording these was faulty. The registered provider did not monitor call bell responses prior to our inspection and the manager was not aware the system of recording these was faulty until the day of our inspection. The manager arranged for the system to be repaired later that day.

There were some gaps in the recording of room checks and position changes in four out of the eight records we sampled. For one person who remained in their room and was unable to use the call bell system the care records stated hourly checks should be completed and there was a two and three quarter hour gap between recorded checks on 11 June 2017 and further gaps of two hours on another day. For another person two hourly position changes were not recorded between 4pm and 10pm. A further person who required two hourly position changes was recorded as remaining in their wheelchair for four hours on the day prior to our inspection and no position changes were recorded on the day of our inspection by 3pm. We saw on 4 June 2017 the manager had audited daily records and written, "More position changes to be done." We discussed this with the manager and they said they felt this was a recording issue and they would address this with staff.

The above issues were a breach of regulation 17 (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems were not in place to assess, monitor and

improve the quality and safety of the service.

On the second day of our inspection the manager had analysed call bell response times for the previous week and addressed response issues with staff. One call bell was sounding for 36 minutes at 5.23am and the manager found the carer had attended the room, but not turned off the alarm. The manager had held supervision with staff to ensure they were aware of the risk of falls and people were clear about how to turn off the alarm when support had been provided.

The management team were visible in the service and the deputy manager and senior support workers regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

The manager said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this. The senior staff told us they felt supported by the registered provider, and were able to contact a senior manager at any time for support. They said they enjoyed working for the organisation and they all worked well as a team and supported each other.

The manager promoted access to the community for people and people were involved in the local church and took part in some activities in the community.

We found the home's records were well organised and staff were able to easily access information from within people's care notes.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. We saw the home sent a survey on a particular area of the service to people every month. The results of the feedback were discussed at each staff team meeting and an action plan developed to address any concerns. We saw action had been taken by the manager in response.

Residents' meeting topics included the menu, activities, cleanliness, care and laundry. One staff member told us a visiting beautician was mentioned at one residents' meeting and this was arranged. Any issues raised had been analysed and addressed by the manager. Some people had asked about more involvement in their care plans. The manager's action plan was to raise this at team meetings for staff to implement and we saw they had taken this action. This action was then displayed on the notice board entitled, "What we asked, you said and we did." This meant people's views were taken into account and they were encouraged to provide feedback on the service provided.

Staff meetings were held every few months. Praise was given to staff and recorded as well as areas to improve. Topics discussed included meal service, staff training, basic care, choice of residents' getting up times, dependency levels and record keeping. Staff requested coloured plates and bowls to contrast with tablecloths for visibility. Actions from the last meeting were discussed and goals were set from the meeting. Meetings had also been held with senior staff and housekeeping staff. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

The manager told us they attended training and good practice events and were currently completing a level five management qualification. The manager had appointed a series of champions in areas such as infection control, activities and health and safety. This meant they were open to new ideas and keen to learn from others to ensure the best possible outcomes for people who used the service.

The manager of the home was proactive in listening and responding to feedback, identifying and addressing concerns and making progress with improving the service. We saw audits were completed in relation to premises and equipment. Audits of medicines were completed monthly as well as regular infection control and recruitment file audits. Care plans and documents were reviewed and audited regularly. A weekly spot check on boxed medicines was also being implemented. This showed staff compliance with the registered provider's procedures was monitored.

Information was passed to the registered provider by the manager every month regarding incidents, complaints, supervision, health and safety and other issues. A quality support manager completed quarterly audits in line with CQC domains. The regional director had completed regular visits to the service to update the action plan, support the manager and complete audits to ensure compliance with the registered provider's policies and procedures. We saw the manager and registered provider had responded to their action plans to improve the service. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation; however, this system had not identified and addressed some of the concerns we found.

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 11 HSCA RA Regulations 2014 Need for consent The consent of the relevant person was not always recorded. People's mental capacity was not always considered when decisions needed to be made and best interest processes were not always evidenced. Regulation 11(1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Adequate numbers of staff were not deployed to meet people's assessed needs. Regulation 18 (1)