Galleon Care Homes Limited

Stokefield Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection that took place on 31 July 2015.

Stokefield Care Home is owned by Galleon Care Homes Limited and is registered to provide accommodation with care for up to 30 people. At the time of our visit, there were 28 older people living at the service. Only a small number of people at the home are living with dementia, whereas others have complex needs. The accommodation is provided over two floors with annexes off each floor that were accessible by stairs and a lift.

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

People were at risk as the provider's recruitment practices were not safe as not all of the relevant checks had been completed before staff commenced work.

Summary of findings

People's medicines were not always managed safely. There was not robust management of medicines to ensure there is a sufficient supply of medicines to meet people's needs. Audits conducted on the management of medicines were not robust to stop poor practice.

People were protected from the risk of abuse because staff knew their roles and responsibilities should they suspect it was taking place. People told us they felt safe at the home. One person told us, I feel very safe here, the staff are lovely." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from abuse.

People were supported by a sufficient staff team, however there were times when staffing levels had an impact on the care provided. We made a recommendation that the provider reviews the staffing levels and deployment of staff to meet people's care and support needs.

People were involved in how they were kept safe at the home. People's risk assessments contained information regarding their behaviour, health and care needs were discussed with them. Any issues that arose would be discussed, along with the involvement of a healthcare professional, such as the speech and language therapist or falls team.

Staff had a clear understanding of what to do in the event of an emergency which would affect the home such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used.

People told us their freedom was not restricted. Staff told us they had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

People's care and support needs could be affected due to care records not being fully completed or kept up to date There were inconsistencies in the recording of people's care records.

Quality assurance checks were not always effective to ensure that the systems in place were managed well. We made a recommendation the provider reviews people's care plan in accordance to their needs.

People had mixed feelings about the quality and variety of food at the home. People had enough to eat and drink throughout the day and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and healthcare professional were involved in the regular monitoring of people's health. The service worked effectively with health care professionals and referred people for treatment when necessary.

The décor of the home was painted in neutral colours. The walls and doors were painted in different colours, enabling people living with dementia or any impairment to move around the home independently. People's bedrooms were personalised with pictures, photographs or items of personal interest.

Staff treated people with kindness and respect. People told us that staff treated them with respect and dignity when providing personal care. People felt that staff knew them well. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

People had access to activities, but these did not always meet individual needs or interests.We made a recommendation that the provider reviews individual hobbies and interests and look at ways and means these could be implemented and people supported to participate.

People said that staff were attentive and responsive to their needs. People's needs were assessed when they entered the service and reviewed regularly. Care records were updated by staff involved in their care. People had access to equipment to assist with their care and support to enable them to be independent.

The provider had sought, encouraged and supported people's involvement in the improvement of the service.

People told us if they had any issues they would speak to the manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

People told us the staff were friendly, supportive and management were visible and approachable.

Summary of findings

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People's medicines were not always managed safely to ensure people had a sufficient supply of their medicines.

People were supported by a staff team, however there were times when staffing levels had an impact on the care provided. Recruitment practices were not always followed and relevant checks had not always been completed before staff commenced work.

There were safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Risks to people's safety were identified and managed well with clear guidance available to help keep people safe.

Requires improvement

Is the service effective?
The service was effective.

Staff ensured they obtained people's consent before providing care and support in accordance with their wishes.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff provided care, and support which promoted well-being. People were supported to have access to healthcare services.

Good

Is the service caring?
The service was caring.

People said that staff were kind and treated with them with respect.

Positive caring relationships had been developed between people and staff.

People told us that staff treated them with respect and dignity when providing personal care.

People felt that staff knew them well and were able to make choices about care and support, so they could maintain their independence.

People's relatives and friends were able to visit to maintain relationships.

Good

Is the service responsive?
The service was not consistently responsive.

Requires improvement

Summary of findings

People's needs were assessed when they entered the service and reviewed regularly. Care records did not always contain up to date information about people care needs.

People had access to activities, but these did not always meet individual needs or interests.

People said that staff were responsive to people needs.

People told us they knew what to do if they needed to make a complaint and were encouraged to voice their concerns or complaints about the service.

Is the service well-led?

Requires improvement

The service was not consistently well- led.

People's care and support needs could be affected due to care records not being fully completed or kept up to date.

Quality assurance checks were not always effective to ensure that the systems in place were managed well.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. People's opinions had been recorded and action recorded.

People told us the staff were friendly, supportive and management were visible and approachable.

Stokefield Care Home

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.

We visited the service on 31 July 2015 and it was an unannounced inspection. The inspection was conducted by three inspectors and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 home, what the home does well and improvements they plan to make.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

During the visit, we spoke with 22 people who use the service, and eight relatives. We also spoke with six members of staff which consisted of care and kitchen staff; we also spoke with the registered manager. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for. We reviewed a variety of documents which included three people's care plans, risk assessments, medicines administration records, five staff files, accident and incident records, minutes of meetings, complaints records, and some policies and procedures in relation to the quality of the service provided.

During the inspection we spoke to a visiting healthcare profession to obtain for their opinion about the service. We contacted the local authority and health authority, who had funding responsibility for some people using the service.

We last carried out a follow up inspection in September 2014 and found no concerns.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and secure living at the home. One person told us, "I moved here as there was always someone around and I feel safe." Another person told us, "I sometimes worry at night when there were agency staff on but was reassured that there were people living upstairs." However during the inspection we identified a concern about the home's recruitment process which compromised people's safety.

People's medicines were not always managed safely. Staff had let one person's medicine run out of stock on four occasions, which meant the person did not receive their medicine when required. A healthcare professional informed us that this medicine was essential for the person's mental health. There was no accurate recording of the issue, action taken, or the impact this omission would have on the person's well-being. This meant that there was not robust management of medicines to ensure there is a sufficient supply of medicines to meet people's needs.

We noted that there was a chart that recorded when staff signed to say they had completed the medicine round and the medicines administration records (MAR) had been checked for gaps was not completed properly. We noted that on six occasions there were no signatures. An audit conducted in June 2015 had identified that staff were not 'signing off' the medicines round. Although this had been highlighted, this was still happening. This meant that quality monitoring arrangements were not effective in stopping poor practice.

Failure to ensure the proper management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the arrangements for the storage and recording of medicines. We found that medicines were stored securely and in appropriate conditions. The medicines administration records (MAR) recorded when medicines were administered. A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. A photograph of the each person was present to ensure that they were giving the medicine to the correct person. We noted that PRN [as needed] medicines information was included, but there were no prompts for staff to indicate what signs people might display if they needed PRN medicines. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register.

Only staff who had attended training in the safe management of medicines were authorised to administer them. Staff attended regular refresher training in this area and after completing this training, the manager observed staff administering medicines to assess their competency before they were authorised to do this without supervision. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff waited patiently until the person had taken the medicine. Staff knew the importance of giving medicines on time and the reasons why this was important to reduce the risk of side effects. Any changes to people's medicines were prescribed by the person's GP.

Medicines policies and procedures were in place to guide and inform staff. These included policies on covert medicines, as and when required medicines (PRN), controlled drugs and medicines errors. Covert medicine is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink.

People had mixed comments about whether there were enough staff on duty to meet their needs or provided the necessary support. One person told us, "There is probably enough staff. It can be busy, but staff were good at balancing the work out." Another person told us, "Staff were excellent but they are trying to do too much with so many people with high needs." They went on to say, "When helping people with their food and with the toilet there aren't enough of them. Staff are trying to do the impossible, people call out for help during lunch and I tell them there's no point as there aren't enough staff to do everything." A third told us, "They (staff) say they come back but they don't. It depends who's working as to how long you have to wait when you call for support, sometimes there are only two staff on. People in wheelchairs have to wait for the toilet."

The registered manager said that there should be a minimum of five staff in the morning and four staff in the afternoon, each shift would include a senior carer and that staffing levels were based on people's assessed needs. The registered manager told us that staff would pull together to cover shifts and if not, bank staff were used. The registered

Requires improvement

Is the service safe?

manager told us that they did not use agency staff. This ensured that there was a consistent staff team who knew people's needs and wherever possible would reduce people's anxiety at meeting new staff. The registered manager informed us that there were a number of vacancies they were trying to fill.

We reviewed the staffing rotas over a four week period which recorded there were a number of occasions where the staffing allocation for both early and late duties were under the minimum staffing levels as calculated by the registered manager to keep people safe. During our visit we saw how staffing levels had an impact on the care people received. We saw positive and negative examples of how staff quickly responded to people's support needs. There were inconsistencies in how long people had to wait for staff to assist them. On occasions staff responded immediately, other times people had to wait longer.

We recommend that the provider reviews their staffing levels and the deployment of staff to ensure that people's care and support needs are met.

People were put at risk because the provider did not carry out the relevant checks as stated in the regulations to ensure staff were suitable to work with adults at risk. There were gaps in the employment history in all of the files we reviewed. This meant that the provider did not obtain sufficient information to be able to determine a person's character or work experience. There was a staff recruitment and selection policy in place which was not always followed.

Failure to obtain information specified in Schedule 3 of the regulations is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provided proof of identification and contact details for references.

Staff said they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. We noted that staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

People were protected from the risk of abuse because staff knew their roles and responsibilities should they suspect it was taking place. Staff understood what to look for when they suspected abuse but not all of them knew how to report it appropriately outside of the service. There was a copy of the most recent local authority safeguarding policy and a service policy on safeguarding adults which provided staff with guidance about what to do in the event of suspected abuse. Staff told us that they had received safeguarding adults training within the last year. We confirmed this when we looked at the staff training programme. All staff stated that they would report the incident to the registered manager.

People lived in a safe environment because appropriate safety checks had been completed. Fire safety arrangements and risk assessments for the environment were in place to keep people safe. There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used and would help minimise the impact to people if emergencies took place.

There were clear guidelines in place to ensure people would be safe in the event of an emergency evacuation of the building. We saw instructions displayed in the home about how to evacuate the building in the event of emergency. We saw in people's care plan a 'Personal Emergency Evacuation Plan.' This meant that staff had information on how to support people in the event of an evacuation.

People were involved in how they were kept safe at the home. People's risk assessments regarding their behaviour, health and care needs were discussed with them. Risk assessments detailed the support needs and routines of people. Risk assessments and protocols identified the level of concern, risks and how to manage the risks. Regular safety checks were carried out on specialist equipment such as pressure and sensory mattresses, profiling beds, call system pendants, wheelchairs and hoists.

Good

Is the service effective?

Our findings

The manager understood their role and responsibilities with regards to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm.

No one had a DoLS application completed and submitted to the local authority as the registered manager told us that everyone had capacity and therefore did not need one. We saw the doors between the different units were not locked and people could move freely around the home. We noted that some people had bed rails in place. Although bed rails were used to prevent people from falling, it could also restrict people's freedom. The registered manager informed us that those had been put in place with people's consent.

People's consent was obtained before care or support was provided. We observed that staff checked with people that they were happy with the support provided and gained their consent. Staff sought people's agreement before supporting them and then waited for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions. This meant that staff ensured they obtained people's consent before proving care and support in accordance with their wishes.

People's care plans contained forms which detailed that consent had been obtained in certain aspects of peoples care. For example in relation to administering medicines or for people who did not want to be resuscitated in the event of a medical emergency.

People told us about the food at the home. People had mixed feelings about the food at the home. Comments included, "I always enjoy my food", The food was nice, but it was stone cold" and "The one thing that lets it down is the food, it's not at all good." Overall the comments about the food were positive, and people from the local community also joined people living at the home for lunch.

We observed the lunchtime experience. The majority of people had their lunch in the dining room. Staff were present during the lunchtime period and offered assistance to people when needed. We observed a member of staff assisting a person with eating. They did this with consideration and sensitivity. They sat next to people who they assisted, and supported people at their individual pace whilst offering words of encouragement. Some people appeared to enjoy the meal, and staff were observed offering and giving seconds to people whilst others did not. The mood throughout lunch was relaxed and friendly and it appeared people were enjoying the atmosphere and each other's company.

The cook was able to explain to us the individual preferences of people and information was in place about people's specific nutritional needs. They told us, "Staff will tell me people's dietary requirements." We noted that there were two people who had diabetes; the chef told us, "We know who they are and they can have normal meals, we just need to be careful with the puddings." People's nutritional needs were recorded in care plans which included their likes, dislikes and preferences. For example one person's nutritional care plan stated 'X likes to have his main meal at supper time or at 2pm, it is up to him when he wants it." This meant that people were support by staff who knew their nutritional and dietary needs and preferences.

People were able to make choices about the food and drink provided. People were asked to choose what they would like to eat from the menu on a daily basis. There was a choice of nutritious food and drink available to people throughout the day and an alternative option was available if people did not like what was on offer. People were offered a choice of drinks and snacks at other times during the day to ensure they kept hydrated.

People were supported by staff that had the necessary skills and experience to support their needs. The registered manager ensured staff had the skills and experience which were necessary to carry out their responsibilities. New staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. Staff told us they received training and support

Good

Is the service effective?

that enabled them to care for people. One told us, "I have had loads of training. The training we had was very useful for the role." Another member of staff told us, "I have done the mandatory training such as manual handling, safeguarding, infection control, MCA, DoLS, and dementia." We reviewed the provider's training programme. Conversations with some staff and further observations of transfer techniques confirmed that staff had effectively integrated this knowledge into their practice to move people safely in the home.

Staff were supported by the registered manager to ensure people received a good quality of care. Staff told us they had regular meetings with their line manager to discuss their work performance and felt supported. One member of staff told us, "I have supervision every six months and I am currently doing my NVQ2." The manager informed us that staff were obtaining professional qualifications in Health and Social care. Staff files included records of supervision and appraisal taken place. We noted that eight staff had not received supervision in last six months. The manager told us that supervisions were being arranged. This meant that staff may miss out on the opportunity to discuss their role and any areas of concern with their manager.

People were supported to maintain good health. People had access to healthcare professionals such as GP, district nurse, dietician, and speech and language therapist and other health and social care professionals. We saw from care records that for any changes to people's needs, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments. We noted that not all outcomes of people's visits to healthcare professionals were recorded in their care records and therefore staff were not always told what actions they should take to keep people well. This meant staff were not always given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

The home had been personalised and modifications made to meet the needs of the people who lived there. The décor of the home was painted in neutral colours, but walls and doors were painted in different colours to assist people to orientate independently. There were clear visual signs on the doors describing the rooms as people who were living with dementia may need help with finding and recognising their bedrooms.

People's names were on their bedroom doors, each had a door bell and a letter box which resembled a front door and some included a photograph of the person as well as a picture of a favourite object so people can recognised their room. People's bedrooms were personalised with pictures, photographs or items of personal interest. If people wanted to paint their room in a different colour they could, and we saw evidence of this. We saw evidence of individual or personal interests integrated into the home outside of their rooms. For example a resident was taking care of plants that have been placed on a window sill near their room.

Good

Is the service caring?

Our findings

People received kind and caring support. People said that staff were kind and treated with them with respect. The atmosphere was relaxed with laughter and friendly joking heard between staff and people. Staff showed kindness to people and interacted with them in a positive and proactive way. One person told us, "The staff are very friendly and respectful." Another person told us, "The staff are kind and we have a laugh."

People confirmed they were actively involved in making decisions about their care and treatment. People were able to make choices about when to get up in the morning, what to wear and activities they would like to participate in, so they could maintain their independence. For example, when being offered drinks, or choice of meal. One person told us, "They are very good here, I am able to do what I like, I can get up when I like. If I want to go out I can." Staff did not rush people for a response, nor did they make the choice for the person. A member of staff told us, "We follow what they want. If people want to get up late then it's their choice." The staff member told me one person got up half an hour before lunch and that's how they liked it." People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them.

People were cared for by staff who knew their individual care needs. Staff patiently informed people of the support they offered and waited for their response before carrying out any planned interventions. We observed people smiling and choosing to spend time with staff. For example there was a large group of people who spent the afternoon together with a member of staff, talking and playing games. They were able to talk about these without referring to people's care records. Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed. We saw information in care records that highlighted people's personal preferences, so that staff would know what people needed from them.

Positive caring relationships had been developed between people and staff. A relative told us, "My family member is very happy and contented here." The manager told us that they spent time "On the floor" with people in order to build relationships of trust and to monitor how staff treated people. It was apparent that people felt relaxed in the manager's and staff's company.

People told us that staff treated them with respect and dignity and promoted privacy when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. We noted that there was a sign on the door stating personal care being given. The manager stated that staff are not to be disturbed when this sign is displayed. People were able to choose if they wanted their door open or closed. We observed that care was given with respect and kindness. We also observed staff guiding people as they walked along the corridor and talking to them in a calm, kind and reassuring way.

Relatives and friends were encouraged to visit and maintain relationships. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. We also saw that religious services were held in the service and these were open to those who wished to attend. A volunteer visitor visited people at the home. We saw a group of people sitting at dining table after lunch, for most of the afternoon, chatting with each other. A member of staff joined them and they played a quiz. There was lots of laughter and it was evident they were comfortable in each other's company. This showed us that care and support were provided with due regard for people's religious persuasion and social needs.

Requires improvement

Is the service responsive?

Our findings

The care plans we reviewed recorded people's care and support needs in relation to communication, mental health and activities. People's interests, religious needs, sleeping, tissue viability, personal care, eating and drinking, continence and strengths were also recorded. All were completed to a basic standard and included risk assessment to a limited degree. The registered manager said that risk assessments were also completed for bedrails, moving and handling needs and support required in the event of an emergency.

However we noted inconsistencies about the information recorded. For example the moving and handling assessment was in place stating that X may need to use the hoist when she was having a bad day. It did not describe which hoist/sling should be used and did not describe what a bad day would look like. Another example was when a person had some bruising there was no information about action taken or how the bruising occurred. We also noted that there were not specific guidelines provided to staff regarding information about settings for pressure mattresses. This meant that staff did not have access to up to date information about people's needs.

People confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. We noted that not all outcomes of people's visits to healthcare professionals were recorded in their care records. We also saw where information had been recorded if any changes had happened such as: wound care, falls, medicines, incidents, accidents and dietary needs.

Daily records were also completed to record support provided to each person; however they were very task orientated. There was no information about people's interactions, activities or mood. This showed us that although there was up to date information about the support provided, the information was not person centred.

We recommend the provider reviews people's care plans to ensure they are person centred and in accordance to their current needs.

People told us that they received care and support that were responsive to their needs. One person told us, that they were able to bring a pet which was extremely important to them and assisted them with their well-being. Staff took action to ensure people were comfortable. For example staff asked if a person was comfortable or would they like an extra cushion, staff were seen adjusting the cushions and blanket to make them more comfortable.

People were supported by staff who knew their care and support needs. Staff told us, "I would get to know someone by talking to them, read their care plan, ask the manager and their relatives." They went onto say "For example, in relation to what care they needed and whether they needed hoisting." They said any changes in someone's needs were reported to the senior to action, but all staff were responsible for keeping care plans up to date. We saw examples of the care and support were provided to people living at the home. For example, a person required her legs to be elevated to stop them from swelling, we saw this had happened. We saw staff explaining to the person the importance of keeping their legs on the support provided. One person's care records identified that staff had noticed a change in a person's mobility and as a result they had been assessed by a member of the Community Rehabilitation Team.

People received care that was based on their individual needs. Although some current information was not recorded, staff were knowledgeable about people's needs. Assessments were carried out before people moved into the home and then reviewed once the person had settled in. Details of health and social care professionals involved in supporting the person such as their doctor and or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs.

People had mixed feels about the activities provided at the home. Some people felt that they had access to activities; whilst others did not feel that they meet their individual needs or interests. People told us of the activities in the home. One person told us, "There is enough for people to do. There were really nice grounds and staff tried to do a lot of activities." Another person told us, "I don't join in activities as they were all centred around people with

Requires improvement

Is the service responsive?

dementia." A third person who had a visual impairment told us they find it difficult to read and do the things she used to. They felt there were limited amount of things to do since the activities co-ordinator had left.

We noted that although activities took place, there was no physical stimulation such as interactive tactile activities or textured surfaces around the home for people to interact with during the day when organised activities were not happening. The registered manager acknowledged that further work was needed to ensure people received stimulation and enjoyable activities and said there was a vacancy for an activity co-ordinator.

We recommend that the provider reviews individual hobbies and interests and look at ways and means these could be implemented and people supported to participate.

We saw that some people attended activities throughout the week and outside in the local community. This information was displayed in pictorial format so people were able to identify what activities they would be attending. Staff told us, "We try to cater for various types of entertainment and at different times of day" and "We are going to have some trips out."

Activities ranged from attending light exercise, listening to music, reminiscence activity, 'pat the dog', manicures and board games. We noted that people from the religious community visited the home, which people enjoyed. We also saw photographs of outings people had attended. For people who did not want to participate in the scheduled activities, staff were available to undertake one to one engagement with them. People from the outside community also joined in on activities held at the home.

We observed people participating in a reminiscence activity which people seemed to enjoy. We noted from one person's care plan they liked gardening and saw it recorded they had attended the gardening club. The home also organised weekly trips to pubs, national and local parks and coffee shops for people to attend as the home has their own transportation.

People were aware of the complaints system and told us that they knew what to do if they needed to make a complaint. People told us that they did not have any complaints and that they felt comfortable to raise issues with staff. One person told us, "The Home is very nice and I can't complain at all." Information about the complaints procedure was displayed in the dining room along with information about other agencies such as the CQC, that could help people if they were dissatisfied with the service. Staff told us that they were aware of the complaints policy and procedure. Staff we spoke with knew what to do if someone approached them with a concern or complaint. There had been no complaints recorded in the last 12 months.

A healthcare professional told us that they had reported concerns regarding a staff member which the registered manager had acted quickly to resolve. We reviewed documentation of a resident's meeting where issues in regards to food, cleaning and activities were discussed. There were records of action taken. We also reviewed a relatives meeting, which recorded relatives opinion about the care their relatives were receiving, quality of the food, proposed seating arrangements for the dining room, this was suggested by staff, so that people could get to know other people living at the home.

Requires improvement

Is the service well-led?

Our findings

We reviewed the audit conducted on the management of medicines and noted issues were identified. For example a PRN protocol needed to be included in X file, ensure all allergy information is completed, we saw that the action had been undertaken. There was a chart that recorded when staff signed to say they had completed the medicine round and the medicines administration records (MAR) had been checked for gaps was not completed properly. We noted that on six occasions there were no signatures. An audit conducted in June 2015 had identified that staff were not 'signing off' the medicines round. Although this had been highlighted, this was still happening. This meant that whilst there were some arrangements in place to monitor systems and standards, people were not fully protected against the risks as there was no systematic approach to managing them.

People's care and support needs could be affected due to care records not being fully completed or kept up to date. There were inconsistencies in the recording of people's care. We reviewed a person's care notes and there was some confusion about their continence needs. One entry in the notes referred to a catheter being used, another entry said they used continence aids for reassurance and a further entry said they were very incontinent. The manager explained that the catheter was no longer used. It was not clear how the decision to stop this was reached as there was no record. There were several other notes in this file which did not have follow up notes stating what action had been taken. The manager told us that if health notes were not recorded on file they would be written in the communication book, so staff would be informed of any changes. This meant that information recorded in multiple places increased the lack of inconsistency when recording information about people's care and may affect the care staff provided.

Quality monitoring checks were carried out by staff as well as the provider to monitor the level and quality of the care provided to people living at the home. We saw records about accidents and incidents that occurred during each month. We noted that there were 14 accidents in July. One person in particular had six falls, but there was no indication of whether or not the person had been referred to the falls team. Many of the forms had missing information. For example, there was information recorded about action taken but there was nothing written about what had been done to prevent reoccurrence. We noted that there was no analysis of the accidents occurred at the home, to identify trends or patterns This meant that although there were systems in place to record accidents and incidents there were no arrangements for monitoring trends or patterns to minimise the risks of events or prevent reoccurrences of accidents or incidents.

The lack of good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. There were a number of systems in place to make sure the service assessed and monitored its delivery of care. We saw there were various audits carried out such as environment, maintenance, care plans, medicine administration records, health and safety, personal care and housekeeping. We noted that fire, electrical and safety equipment was inspected on a regular basis.

People and staff said that the manager and staff were approachable and open to suggestions. One person told us, "The manager was approachable, always had an open door and was seen around the home." The manager told us they conducted a daily walk-round to see people and check on possible problems.

People were supported by a consistent staff team. Staff said that they worked well as a team and at time senior staff members acted as carers which was good as it gave them a sense of what the carers did. One person said, "I feel supported by the manager. It was rare for her door to be shut. She always speaks to the residents and helps out when needed." They went on to say, "She's really good with the residents." Another member of staff told us, "We all get on well and residents benefit."

People were involved in how the service was run in a number of ways. The manager told us that questionnaires had been given to people and relatives and was awaiting the results of the survey from Head office. With regard to responding to suggestions by people the manager told us that a relative had said that activities needed to be improved. At present the manager and staff were carrying out activities in the absence of the activity co-ordinator.

Staff were involved in the improvement of the delivery of the service provided. We reviewed minutes of a senior staff

Requires improvement

Is the service well-led?

meetings. The information recorded included issues such as laundry, staff duties, training and supervision. Actions identified and undertaken were recorded. Minutes of staff meeting were held and staff discussed issues such as laundry, menus, medicines, training and domestic staff. Actions were taken from the suggestions which had been made and any actions undertaken were recorded.

Staff had a good understanding of their responsibilities, for example sending in notifications to the CQC when certain accidents or incidents took place. We found during our inspection the registered manager had a clear working knowledge of the home and the people living at the home and was able to answer our questions easily or provide us with the information we required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered provider failed to obtain information specified in Schedule 3 of the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider failed to ensure the proper management of medicines. Regulation 12 (1) (2) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not ensured accurate, complete and contemporaneous records were held.