Firstsmile Limited

Framland

Inspection report

The Mansion House
11 Faldo Drive
Melton Mowbray
Leicestershire
LE13 1RH

Tel: 01664564922
Website: www.newbloom.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Framland on 23 May 2017. The visit was unannounced. This meant that the staff and the provider did not know that we would be visiting.

Framland is located in Melton Mowbray, Leicestershire. The service provides accommodation for up to 31people who require personal care. There were 27 people using the service at the time of our inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 told us they felt safe living at Framland. The staff team knew their responsibilities for keeping people safe from harm. This included reporting any concerns to a member of the management team.

Assessments had been carried out on the risks associated with people's care and support. This enabled the registered manager and management team to identify and reduce the risks presented to both the people using the service and the staff team.

People's thoughts on staffing levels at the service varied. Whilst some people felt there were enough staff members to meet their needs, others did not. This resulted in people having to wait for support from the staff team or it having an impact on the care they preferred.

Appropriate checks had been carried out when new members of staff had started working at the service. This was to make sure that they were suitable and safe to work there. An induction into the service had been provided and on-going training was being delivered.

There were systems in place to audit the medicines held at the service and appropriate records were being kept.

Not all areas within the home were clean, appropriately maintained or hygienic.

People received support from a staff team that had the necessary skills and knowledge. New members of staff had received an induction into the service when they were first employed and training relevant to their role had been provided.

People had been involved in making day to day decisions about their care and support. Where people were unable to make their own decisions, these had been made for them in consultation with people who knew them well and in their best interest. The staff team were working in line with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

People's nutritional and dietary requirements had been assessed and a balanced diet was being provided. For people who had been assessed to be at risk of not getting the food and drink they needed to keep them well, appropriate records were kept so that this could be monitored.

People were supported to maintain good health. They had access to relevant healthcare services such as doctors, community nurses and opticians and they received on-going healthcare support.

People told us that the staff team were kind and caring. The relatives we spoke with agreed with this. On the whole we observed the staff team treating people in a kind manner though there were some occasions where this could have been improved.

Whilst activities for people using the service were being provided, these were being carried out by the care staff team alongside their other duties. Records did not always show that people were regularly supported to follow their hobbies or interests.

People had plans of care that reflected their care and support needs. These provided the staff team with the information they needed in order to properly support people using the service though these had not always been followed. Staff knew the people they were supporting including their likes and preferences.

A complaints procedure was in place and people we spoke with were aware of who to talk to if they had a concern of any kind.

The staff team felt supported by the registered manager. They were provided with the opportunity to meet with them on a regular basis and felt able to speak with them if they had any concerns or suggestions of any kind.

Staff meetings and twice monthly surgeries for the people using the service and their relatives and friends were being held. These provided people and staff with the opportunity to be involved in how the service was run. Surveys were also being used to gather people's views on the service provided and the feedback was used to make improvements.

A business continuity plan was in place for emergencies or untoward events and personal emergency evacuation plans were in place should people using the service need to be evacuated from the building.

Whilst there were systems in place to regularly monitor the quality and safety of the service being provided these had not identified the shortfalls identified during our visit or rectified the shortfalls identified at our last visit in March 2016. This included infection control issues identified within the environment and with regards to the monitoring of records.

The registered manager understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred or affected people using the service.

We found the service was in breach of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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 consistently safe.

People we spoke with did not always feel that there were enough staff suitably deployed to meet people's needs.

Suitable arrangements were not in place for keeping the service clean and hygienic.

Risks associated with people's care and support had been appropriately assessed.

People told us they felt safe and the staff team knew their responsibilities for keeping people safe.

An effective recruitment process was followed.

Medicines had been audited and appropriate records were being kept.

Is the service effective?

Good

The service was effective.

The staff team had received training and had the knowledge they needed to be able to meet the needs of the people using the service.

People's consent to their care and support was sought and the staff team understood the principles of the Mental Capacity Act 2005.

A balanced and varied diet was provided and people were always offered choices.

People were appropriately supported to access healthcare services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's care and support needs were not always met in a caring or respectful way.

People's privacy was respected.

The staff team understood the needs of the people they were supporting.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Whilst people's plans of care reflected the care and support people needed, these were not always followed.

Whilst activities were provided there was no evidence that people were supported to follow their preferred hobbies or interests.

People's needs had been assessed before they moved to the service.

A complaints process was in place and people knew who to speak with if they were unhappy with the service provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Monitoring systems were in place to check the safety and quality of the service being provided. However, areas we identified as requiring improvement had not been addressed in a timely manner nor had shortfalls that we identified during our visit been highlighted by these checks.

Staff members we spoke with felt supported by the registered manager.

People were given the opportunity to have a say on how the service was run.

The registered manager was aware of their registration responsibilities with Care Quality Commission.

Framland

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 May 2017 and was unannounced. The inspection team consisted of two inspectors.

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. The provider returned the PIR and we took this into account when we made judgements in this report. We also reviewed other information that we held about the service such as notifications. These are events which happened in the service that the provider is required to tell us about.

We contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had any feedback about the service. We used this information to inform our inspection planning.

At the time of our inspection there were 27 people using the service. We were able to speak with five of the people living there and with four relatives of other people. We also spoke with the registered manager, the nominated Individual for the service, the cook, a care worker and two senior care workers. A visiting professional was also spoken with to gather their view of the service provided.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. This included four people's plans of care. We also looked at associated documents including risk assessments and medicine administration records. We looked at records of meetings, the staff rota and training matrix, one staff recruitment and training file and the quality assurance audits that the management team had completed.

Requires Improvement

Is the service safe?

Our findings

People's thoughts on staffing numbers varied. Whilst some of the people we spoke with felt there were sufficient staff members on duty, others felt that at times, particularly in the afternoons and evenings, there were not. One person told us, "I do think they are short staffed sometimes, particularly at mealtimes, sometimes we have to wait quite a while. I only have one shower a week, I would prefer more showers but there is not enough staff for me to have that, I have my hair washed once a week." Another explained, "Sometimes I ask them to do something and they say they will be back in five minutes and they never get back to you." A relative told us, "There seems to be plenty when I come in [staff members]. If I want something I just ask them and they get it." A second though explained, "I don't think there are always enough staff. Often there are not enough staff in the evenings."

When we discussed the staffing levels with the staff team, their views varied. One staff member told us, "I don't think there are enough staff particularly in the afternoon. Weekends are usually ok though, we use agency staff often at weekends. Another explained, "I feel there are enough staff on to meet people's needs." A third told us, "There are not enough staff; there is no activities person and no kitchen assistant in the afternoon. It is difficult if people need to go to the toilet and need hoisting."

Observations showed us that at times people were left to their own devices due to the staff being busy carrying out other people's care and support. This included a number of people left sitting at the dining room tables after breakfast. People were there for a substantial amount of time with little or no interaction either with each other, or with the staff team. Whilst we were told that this was their preference, we did not see staff members checking whether they would like to be assisted to another part of the home.

We discussed the staffing numbers with the registered manager. They explained that a dependency tool was used to determine the numbers of staff required for each shift and this was reviewed on a monthly basis so that appropriate numbers of staff were available. On the day of our visit there were three care workers and a senior care worker working during the day and two waking care workers at night. We were told that the registered manager also made themselves available to support the staff team when required. Whilst it was evident that the registered manager was monitoring staffing levels on an on-going basis, observations and feedback on the day of our visit questioned its effectiveness.

We looked at the way people's medicines had been managed to see if people had received these as prescribed. We checked the medicines and corresponding records to see that the medicines had been appropriately signed for when it had been received into the service, which it had. We also checked to see it had been appropriately signed for when it had been administered, which again it had. Protocols were in place for people who had medicines as and when required, such as paracetamol for pain relief. These protocols informed the reader what these medicines were for and how often they should be offered. We did note that the protocol for a medicine which was given for agitation was limited in the information written to guide staff and did not include at what stage of their agitation this should be offered. We discussed this with the registered manager and the protocol was amended.

We observed the senior care worker administer medicines to people. Each time they checked the medicine against the medicine administration record (MAR). Once satisfied they took them to the person and explained they had brought their medicines. They waited whilst they took them and they did not rush them. Once satisfied the person had taken their medicine they signed the MAR and started the process again. Whilst during our visit we saw people being provided with their medicines in a safe way, comments received showed us that this was not always the case. A relative told us, "I have been in before and seen her tablets in a pot on the table next to her. I have also found a single tablet on her dress. That's a worry." One of the people using the service explained, "I get my medicines in the morning and night time. The night staff give me my hot drink and tablets then leaves me to take my tablets when my drink has cooled down." Another explained, "They don't stay with me whilst I take them [their tablets]." We shared this with the registered manager who looked into the issues raised. They assured us following our visit that the night staff did not leave tablets with people for them to take later.

At our last inspection in March 2016 and our previous inspection in October 2014, concerns had been identified with regard to possible infection control risks within the service. This included concerns with regard to the flooring in the laundry room and general cleanliness issues. At this inspection we again found issues with regard to possible infection control risks. The laundry room flooring remained in a poor condition and the skirting boards were dirty. The flooring in the ground floor communal toilets were dirty and badly stained. In one of the toilets the flooring had lifted and was unhygienic. One of the people using the service told us, "The toilets are not clean, the other night I ended up going to bed early to use my ensuite toilet as the toilets down stairs were very dirty." Another person explained, "I am happy with everything apart from the toilets. The toilets are not clean." We discussed our concerns with the Nominated Individual who acknowledged that these areas should have been addressed following our last visit. We were provided with a copy of the provider's refurbishment plan which showed that the floors identified were due to be replaced by 10 June 2017.

Not all of the equipment used to support people to move safely was found to be clean or hygienic, with one piece of equipment being extremely dirty. We shared this with the registered manager and this was attended to on the day of our visit. This made sure that it did not continue to pose an infection control risk.

Some areas of the service looked tired and in need of attention. This included two of the lounges and the first floor corridor where the woodwork including hand rails and skirting boards were badly chipped. The registered manager told us, and the provider's refurbishment plan showed us that these areas were due for redecoration in the near future.

People we spoke with told us they felt safe living at Framland and they felt safe with the staff team who supported them. One person said, "Some staff are better than others. None of them make me feel frightened, some you just get on with better. None of the residents make me feel frightened." Another told us, "I do feel safe, I don't have a worry." Visitors we spoke with agreed that their relatives were safe living at the service. One told us, "I feel my mum is safe here." Another explained, "[Relative] is safe here, she was having falls at home but she's not had one here."

People using the service were kept safe from avoidable harm because the staff team knew their responsibilities for safeguarding them. They were aware of the types of abuse they could encounter and the signs to look out for if they were concerned that someone might be at risk of harm. The staff members we spoke with knew the process to follow should they have any concerns of any kind. One staff member told us, "I would report any concerns to my manager; I have not seen anything that would make me worried." Another explained, "I would contact [registered manager] and I would contact social services and the police [if necessary]."

The registered manager was aware of their responsibilities for keeping people safe. They knew the procedure to follow when a safeguarding concern had been raised with them. This included referring it to the local authority safeguarding team who have responsibility for investigating safeguarding concerns and the Care Quality Commission.

When people first moved into the service, the risks associated with their care and support had been identified and risk assessments had been developed. These had then been reviewed on a monthly basis to ensure they remained up to date and accurate. Risks assessed included those associated with people's mobility, their eating and drinking and falls. This meant that any risks could, wherever possible, be minimised, controlled and properly managed by the staff team.

Checks had been carried out on both the environment and on the equipment used to maintain people's safety. Fire safety checks had been carried out and the staff team were aware of the procedure to follow in the event of a fire. There were personal emergency evacuation plans in place for the people using the service. These showed how each individual must be assisted in the event of an incident and a plan was in place in case of foreseeable emergencies.

The provider's recruitment procedures had been followed. Required checks had been carried out prior to a new member of staff commencing work. This included obtaining suitable references and a check with the Disclosure and Barring Service (DBS). A DBS check provides information to the provider as to whether someone is suitable to work at the service.

Good

Is the service effective?

Our findings

People using the service told us the staff team knew them well and had the skills and knowledge they needed to look after them properly. One person told us, "Staff know my routine, they bring me a hot drink and clean towels in the morning, then I can get myself up." Another explained, "Staff know what they are doing." A relative told us, "I feel they [staff team] are properly trained, I've seen them with the hoist and they know what they are doing."

The registered manager explained that staff members had been provided with an induction into the service when they had first started working there and training suitable to their roles had been completed. Staff members we spoke with and the training records we looked at confirmed this. One staff member told us, "I have started my training and induction. I shadowed people when I first started and was shown around the building."

Monthly team meetings had been held and regular supervision sessions had been completed. Supervision provides the staff team with the opportunity to meet with the registered manager to discuss their progress within the staff team. One care worker explained, "Feedback is given in supervision, we are told where we are doing well and where we can improve."

The staff members we spoke with told us that the registered manager was supportive and always available if they needed any help or advice. One staff member told us, "I feel supported in my role, if I have any problems I can always talk to the manager, we just have to ask."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood their responsibilities with regard to the MCA. Applications for DoLS authorisations had been made in respect of people who lacked the mental capacity to make their own decisions about their care and support and where there were restrictions upon their freedom. At the time of our visit there were three authorised DoLS in place. We did note that one person's DoLS had a condition that stated they should be encouraged to do meaningful activities. There was limited evidence of this occurring. The registered manager explained that activities were encouraged but these had not always been accepted or recorded as being offered.

Mental capacity assessments had been carried out to determine whether people lacked the capacity to make a decision about their care or support. For example, an assessment had been completed when deciding whether to accept support with their personal care to determine the person's understanding. Where capacity had been assessed as lacking for specific decisions, a decision had been made with others on their behalf and in their best interest.

People told us they had been involved in making day to day decisions about their care and support and the staff team gave examples of how they obtained people's consent on a daily basis. One person told us, "They will ask if it is alright for them to do something." Another explained, "They make sure I am happy for them to help me and they encourage us to be as independent as possible." A staff member told us," We support people to make decisions by giving choices. I try not to overwhelm someone by too much choice but I would offer two shirts then two tops. I would show them and wait for them to decide. It would the same for their meals." Another explained, "I always ask someone first if I can help them and I prompt them to do as much as they can for themselves."

We asked people what they thought about the meals served at Framland. One person told us, "The food is very good; there are always two choices at lunch. Breakfast; there is cereal, toast, eggs and bacon if you want. Today's lunch is steak pie or cheesy veg. There's always a choice of sweet. There is plenty, you can have more if you want more. Tea time is sandwiches and something on toast, you get loads. We have drinks in the morning and afternoon and in the evening about 7.30pm, we have a hot drink and a sandwich." Another person explained, "The food is very nice it suits me anyway. I get enough, there's a nice atmosphere in the dining room and you sit where you like. We get plenty of drinks and snacks during the day. At night we have a drink and a snack."

At mealtimes we saw the tables were set with table cloths, serviettes and flowers and salt and pepper was available. A choice of drink was offered. Menus were devised on a four weekly cycle and provided a variety of meals and choices. For people who did not like what was on the menu, an alternative was offered.

Whilst people were supported appropriately to eat their meal, we noted that this was not always carried out by the same staff member for each person requiring this support. For example, a staff member started to encourage one person to eat their lunch however; they then needed to do something else and so left the person. Another staff member then came to encourage them to eat. This was then followed by a third staff member a few minutes later. Although staff did support them appropriately by getting down to the person's level, it was rushed and lacked a personal focus on supporting the person to eat.

The cook had information about people's dietary needs. They knew about the requirements for people who needed a soft diet and for people who lived with diabetes. Monitoring charts to document people's food and drink intake were used for those people assessed to be at risk of not getting enough to keep them well. The records we looked at had on the whole been completed consistently. A recommended daily fluid intake had been identified and the fluids being taken were totalled at the end of the day. These charts demonstrated that people were receiving the food and drink they needed to maintain their health.

People using the service had access to the relevant health professionals such as doctors, chiropodists and community nurses. This was evidenced through talking to them and their relatives and checking their records. One person told us, "I see the GP when I need to and the optician; I had a new pair of glasses recently." Another explained, "I see a GP when I need to, they [staff team] are very good like that, I see a nurse regularly as well. I see the chiropodist about every six weeks, they are due tomorrow I think. I also see an optician who comes to the home." A visiting health professional told us, "There is always a member of staff available to assist us and they always contact us if they are concerned about anyone. The care is better

now and they know about the people living here."

Requires Improvement

Is the service caring?

Our findings

We observed the staff team involving people in making choices about their care and support. People were given choices about how they wanted to spend their time, where they wanted to sit, what they wanted to eat and drink and whether they wanted to join in an activity that was being carried out. The staff team respected the choices that people made.

We did note through talking to people using the service that they were not always given the choice as to whether they preferred a male or female staff member to support them with their personal care. One person told us, "No I wasn't given a choice, it was just who was available. I wasn't happy to start with but I am used to it now." Another person explained, "I have never been asked if I would prefer a male or female carer. We have a lot from agencies; I sometimes have had male carers." This meant that people were not always offered a choice in relation to the care and support they received.

We observed support being provided throughout our visit. The staff team showed a good understanding of people's needs. We saw examples of staff supporting people in a caring manner. For example we saw them getting down to people's eye level when talking with them. However we also observed some staff members not supporting people in such a caring manner. When one person was assisted to use a hoist we saw staff members having a conversation between themselves rather than talking to the person they were supporting.

During lunchtime we observed the staff team providing people with aprons to protect their clothes. However, they did not always ask permission to put the apron on. We noted one staff member putting an apron over a person's head without explaining what they were doing. This person was not supported in a caring manner. For people who did not wish to sit in the dining room for their meal, they were provided with their meal in one of the lounges. During tea time we observed one person who was sat in their easy chair being handed a bowl of peaches and cream. There was no table, apron or serviette offered to them. The person proceeded to eat the meal but spilt the majority of it down their clothes which were already stained from the previous meal. This person was not supported in a caring manner when eating their meal.

People we spoke with told us the staff team at Framland were kind and caring and they looked after them well. One person told us, "Staff are mostly kind and caring. They have a lot to put up with. I find if you are okay with them they are okay with you. They do treat me with respect, even the male carers are good." Another explained, "When they help me in the shower or to get dressed they are always very respectful, I don't feel embarrassed. They close the curtains every time."

Relatives we spoke with told us that in their opinion the staff team were kind and caring. One told us, "The staff are very caring." Another explained, "I think the care she [relative] gets is very good, they [staff team] are very caring, she is happy here and that is important."

We saw the staff team respecting people's privacy and they gave us examples of how they did this. One staff member explained, "We knock on people's doors, shut curtains and make sure they are covered up when

doing personal care. We also make sure other staff don't come in. Also we wouldn't shout out across the lounge to ask if someone needed the toilet. We are discreet if they need the toilet." Another explained, "I wouldn't go into the toilet unless I needed to. I would cover the person with a towel whilst doing personal care; I would use a dressing gown and would ask if they wanted help. I would also close the door and curtains."

We looked at people's plans of care to see if they included details about their personal preferences and their likes and dislikes. We saw that they did. The staff team knew what people liked and disliked. For example what people preferred to be called and what they liked to eat and drink and they ensured that personal preferences were upheld. One person told us, "They know what I like and what I don't like." A relative told us, "[Relative] likes bread and jam, they found this out and they gave her bread and jam."

The registered manager had recently sourced training in equality and diversity. Six staff members had completed this to date and a further training date was being arranged for the remaining members of the staff team. This meant that the staff team would gain the understanding they needed in order to meet and protect people's diverse needs in a caring way.

Relatives and friends were encouraged to visit and they told us they could visit at any time. One relative told us, "I don't feel I need to come every day, but I could if I wanted to." Another explained, "We can visit anytime."

For people who were unable to make decisions about their care, either by themselves or with the support of a family member or friend, the registered manager made sure that advocacy services were made available to them. Written information was available and this meant people had access to someone who could support them and speak up on their behalf if they needed it. We did note that this information was displayed in the office rather than in a prominent place where the people using the service and/or their relatives could easily access it.

Requires Improvement

Is the service responsive?

Our findings

The people using the service had been involved in the planning of their care with the support of their relatives, though not all of the people we spoke with could remember this. A relative told us, "We looked around and were asked what sort of help [relative] needed." Another explained, "We [family] all came and looked around and they carried out an assessment at the hospital. We were involved in the assessment process."

The registered manager explained that people's care and support needs were assessed prior to them moving into the service. This was confirmed through looking at people's records. By carrying out this assessment the registered manager could be confident that people's needs could be met by the staff team working at the service. From the initial assessment, a plan of care had been developed.

The plans of care we looked at covered areas such as, communication, nutrition, mobility, skin integrity and safety. These had been reviewed on a monthly basis. However, whilst some of them showed evidence that they had been reviewed with the people themselves or with someone who knew them well others did not. One person told us, "I have seen my care plan and they do tell me if it is changed." Whilst another explained, "I have never seen my care plan, never been involved." A relative told us, "They shared mum's care plan with me and they discuss her needs when they change."

For people who lived with insulin controlled diabetes, a plan of care was in place to show the actions to be taken to support them and to keep them well. We found that these were not always being followed. One person's plan of care stated that prior to them having their insulin, their blood sugar levels should be checked. It recorded the range that the blood sugar level should be between and instructed the senior team that if the person's blood sugar levels were outside of this range they should contact the person's doctor or specialist nurse. We noted that between 18 March 2017 and 29 March 2017 there were 10 occasions when the person's blood sugar levels were outside of this range. There was no mention of this in the daily records and there was no evidence that their doctor or the specialist nurse had been contacted. Another person's plan of care stated that their blood sugar levels should be taken twice a day and if their levels were high these should be taken again after a certain time to see if this had reduced. The plan of care showed us, and a senior member of staff confirmed, that their normal blood sugar level should be around 18 and if over 20 it should be checked again. When we checked the records we found numerous entries that showed that their sugar levels were significantly above this and no evidence was seen that the plan of care had been followed. For example, on 5 May 2017 a reading of 38.2 was taken at 4.40pm, it was not checked again until 8.00am the next day when a reading of 20.2 was taken. On the 14 May 2017 a reading of 27.1 was taken at 8.00am, the person's blood sugar was not checked again until 4.00pm when it was 18. There was no evidence that the plan of care had been followed or advice had been sought from a diabetic nurse with regard to the high readings recorded.

A document entitled 'My life history' was included in the plans of care we looked at. These gave the reader information about the person's past history and their likes and dislikes such as their favourite food and what they liked to be called. Staff members we spoke with were aware of people's likes and dislikes.

People were offered opportunities to be involved in activities. However, it was not always evident that people's interests had been explored. An activities plan was included within people's care records. This instructed the staff team to 'spend time talking about past hobbies and interests and establish hobbies and interests that people can still enjoy. However there was no evidence that this had been carried out or that people's preferred hobbies and interests had been recorded. Following our visit an activities preference sheet was devised to show what people liked and disliked. This meant that the staff team, time permitting, would be able to provide activities that people liked and preferred. One person told us, "I wasn't asked what my interests and hobbies were. They do have entertainment. We have a singer coming in and another person comes in and does a quiz. We don't do anything though, well anything that makes us feel helpful or valued. I know not everyone here can, but some of us could still do bits and pieces." A relative told us, "They don't seem to do anything with them or give them stimulation."

A member of the care team was responsible for providing activities throughout the week. It was noted however that activities had to be fitted around other duties such as people's care and support. Records showing the activities provided on a daily basis were not always thorough to show what had been provided and to whom. The quality of this type of activity provision was discussed with the registered manager and nominated individual who felt that currently this was sufficient. However one staff member told us, "I don't think there are enough staff particularly in the afternoon. If you have to do the kitchen and activities it's a lot." On the morning of our visit a staff member encouraged people to get involved in a game of frisbee. During the activity people appeared more lively and interacted with staff. We also saw photographs of previous activities being carried out including gardening in the newly refurbished garden and people joining in a music activity. Whilst it was evident that some activities were taking place, observations and feed back on the day of our visit brought into question how meaningful and effective the current system to support people to follow their interests and take part in social activities was.

A formal complaints process was in place and this was displayed for people's information. People we spoke with knew what to do and who to talk to if they had a complaint or concern of any kind. One person told us, "If I was worried about anything I would speak to [registered manager]." Another explained, "The manager is [name], I would happily talk to her if I had a problem." A relative explained, "I would talk to [registered manager] she would do something about it." Complaints received had been handled in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

The provider had monitoring systems in place to check the quality and safety of the service being provided. Daily, weekly and monthly checks had been carried out. These included checks on people's medicines and the corresponding records that were in place, people's plans of care, accidents and incidents and health and safety. The provider's regional manager also carried out audits on a three to four monthly basis and visited the registered manager on a weekly basis to support them in their role. We noted that the monitoring systems that were in place had not identified the shortfalls we found during our visit. For example, the staff team had not followed instructions within people's plans of care when supporting them with their diabetes. This meant that systems put in place to monitor the risks relating to people's health and welfare had not been followed.

Plans of care did not always include people's identified interests or hobbies and activity records did not always show what activities were offered and to whom. Audits that were in place had failed to identify this. This showed that systems put in place to assess, monitor and improve the quality of the service had not been effective.

Regular checks had been carried out on the equipment that the staff team used and on the environment. Whilst issues had been identified within the environment including the flooring within the laundry room and communal toilets, these had still not been improved since our last visit in March 2016. We were informed that these works were due to be completed in June 2017. We also saw that the monitoring processes that were in place had not identified dirty equipment that was in use.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

People we spoke with told us that they felt the service was properly managed and the registered manager and the staff team were friendly and approachable. One person told us, "The manager is [name] and she is friendly." A relative told us, "I do feel the home is well led. [Registered manager] is approachable, she really is."

Staff members we spoke with told us they felt supported by the registered manager and felt able to speak to them if they had any concerns or suggestions of any kind. One staff member told us, "The culture is open, we are encouraged to raise issues, the manager does encourage us, and she has an open door policy. She knows what is happening in the home. I feel supported in my role, if I have any problems I can always talk to the manager." Another explained, "I do feel supported. The manager is always available and if not here, she's only a phone call away." A third told us, "I think it is well-led, it's a lovely home and the staff are great."

Monthly staff meetings had taken place. The minutes of the last meeting held showed that issues such as the correct completion of records and laundry requirements were discussed. A staff member told us, "We have staff meetings monthly and we discuss any risks."

People using the service and their relatives and friends were encouraged to share their thoughts of the service provided. This was through daily dialogue and twice monthly surgeries held by the registered manager. A relative explained to us that they were aware of the surgeries held on the first and third Thursday of every month and they hoped to attend one soon.

The registered manager explained that they had used surveys to gather people's views of the service provided. The last survey had been carried out in February 2017 with six surveys being returned. These had been completed by one of the people using the service, one relative, two friends and two medical professionals. People's thoughts of the service had been taken on board and an action plan had been developed. This included making improvements to the garden, the communal lounges and the dining room. We noted that improvements had already been made to the enclosed garden and improvements to the communal areas were planned for June 2017.

The registered manager was aware of and understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred for people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events. We saw that the ratings poster from the previous inspection had been displayed. The display of the poster is required by us to ensure the provider is open and transparent with the people using the service, their relatives and visitors.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance System's in place to assess, monitor and improve the quality and safety of services were ineffective. Systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were ineffective. The provider had failed to act on feedback from relevant persons in the carrying on of a regulated activity.