Ivydene Care Home Limited

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

Summary of findings

Overall summary

We carried out an unannounced inspection visit to the service on 6 October 2016. This meant that the registered manager and provider did not know we would be visiting.

Ivydene Care Home provides care and support for up to 23 older people. At the time of our inspection 18 people were using the service many of who were living with dementia. The accommodation was offered over two floors. There were two communal lounges and two dining areas.

At the time of our inspection there was a registered manager in place. It is a requirement that the service has 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.

The provider had not always followed their policy and local safeguarding guidance when responding to suspected or actual abuse. This meant that the police and local safeguarding team were not able to investigate concerns at the time they occurred.

People were not always supported in line with the Mental Capacity Act 2005 (MCA). The provider had not assessed people's mental capacity to make specific decisions where this was necessary. Decisions had not always been made in people's best interests. This meant that people may have received care that was not in their best interests. The registered manager told us they would complete the assessments. We saw that some people had restrictions placed upon them as they were not able to go out independently and may not have had the capacity to make a decision about their safety. Applications to ensure these restrictions were lawful were made to the local authority. Staff understood their responsibilities under the MCA and sought the consent of people when delivering care.

The provider did not meet the requirements of their registration with CQC. The provider did not always submit statutory notifications to CQC following significant incidents at the home as required by law. We also found that the provider did not display their rating from the latest CQC report. This is a legal requirement to inform people about our judgement about the quality of the service provided. The provider told us they would make sure the rating was displayed within the home and on their website.

Staff members understood their responsibilities to protect people from harm and to remain safe. We saw that the provider had a system to manage accidents and incidents. However, the analysis and investigation of these by the registered manager was not always recorded. This meant that there was a risk that measures put into place to help people to remain safe were not always monitored to check their effectiveness when an incident occurred. The registered manager told us they would use their incident forms more thoroughly in the future to detail their investigations.

People told us they felt safe. However, we saw there were some risks to people's health and well-being. This included equipment stored against a fire door. The provider told us they would remove the items. We saw that the provider had plans in place to keep people safe during emergencies such as a fire. The provider also regularly checked the safety of the environment and equipment to reduce risks to people's safety.

People's care records did not always detail their specific health care requirements to support them to maintain their health. For one person there was no guidance for staff about what constituted a suitable blood sugar level for them to determine if the advice of a health professional should be sought. The registered manager told us they would make improvements to people's care records. People had access to regular health care professionals to maintain their health including their GP.

People did not always receive care when they required it. For example, some people spent periods of time without staff enquiring if they wanted to engage in an activity or if they required support. The provider had not adapted the environment to be responsive to people living with dementia such as having clear signs to help people know where they are.

People and their relatives were not satisfied with the amount of activities offered to them. On the day of our visit some activities were occurring including one-to-one activities with people. The provider had displayed a notice asking relatives for activity suggestions.

The provider's quality checks were not always suitable to ensure people received good care. We found concerns during our visit that were not identified by the provider's own audits. These included the provider not always notifying the correct authorities following significant incidents.

People were involved in decisions about their care wherever possible and information on advocacy services were made available to help them to speak up where this may have been required. People were supported to be as independent as they wanted to be in order to retain their skills and abilities. People or their representatives had opportunities to contribute to the planning of their care where they were able to. People's care plans were regularly reviewed but did not always contain information specific to all areas of their care requirements.

The provider had a suitable recruitment process in place for prospective staff which included relevant checks. People, their relatives and staff felt there were enough staff to offer safe care. We found staffing numbers to be appropriate to meet people's needs safely.

People received their prescribed medicines in a safe way at the time they required them. Staff recorded the administration of people's medicines and handled them in line with national medicines guidance. We saw that staff were trained in the safe handling of medicines and their competency was due to be checked by the registered manager to make sure they continued to have the required skills and knowledge.

People received care from staff who received regular training and guidance on their work. Staff undertook training in topic areas such as assisting people to move and in fire safety. New staff received an induction when they started working for the provider so that they were aware of their responsibilities. Staff members also met regularly with a manager so that they could gain feedback on their work.

People were satisfied with the food and drink available to them and mealtimes were relaxed. Their likes and dislikes were known by staff. Where there were concerns about people's eating and drinking, specialist advice had been sought and incorporated into the support that staff offered. This included modifying people's diets where this was required to support people to maintain their health.

People received support from staff who were kind and compassionate. Staff protected their dignity and privacy by, for instance, closing dividing curtains within shared rooms when delivering care. Staff knew the people they supported including their preferences and life histories. People's care records were stored safely in line with the provider's policy to maintain their confidentiality. People and their relatives told us that visitors were made welcome and could visit without undue restriction.

People's relatives knew how to make a complaint should they have needed to. The provider had a complaints policy in place which was displayed so that visitors knew the process. The provider had not received any complaints in the last 12 months.

People, their relatives and staff felt that the service was well-led and had opportunities to give feedback to the provider. Staff felt supported by the registered manager and they were aware of their responsibilities. They knew how to report the inappropriate or unsafe practice of their colleagues should they have needed to.

We found four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider did not always take the appropriate action in line with their policy or local safeguarding procedures when suspected or actual abuse took place.

Risks to people's health and well-being were regularly assessed. The provider did not always record their investigation following an accident or injury to reduce future occurrences.

Staffing numbers were suitable to meet the safety needs of people and staff were checked for their suitability before they started working for the provider.

People received their prescribed medicines when they required them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported in line with the Mental Capacity Act 2005. Assessments to understand people's capacity to make specific decisions were not completed by the provider.

People's health records were not always completed in relation to their specific requirements. People had access to healthcare services.

Staff sought people's consent when delivering care.

People received support from staff who had received regular training and guidance on their work.

People were satisfied with the food and drink offered to them.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion from staff.

People's dignity and privacy was respected.

People's independence was encouraged where this was important to them. People's preferences were known by staff including their life histories.

People were involved in making decisions about their care and support where they could. Information on advocacy services was available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care when they required it.

People did not feel that there were sufficient activities offered to meet their interests. Some activities were occurring during our visit.

People or their representatives had opportunities to contribute to the planning and reviewing of their care needs.

People's relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not always meet their registration requirements with Care Quality Commission.

The provider did not always have effective processes in place to monitor the quality of the service to ensure it was of a good standard.

Staff received regular support and were aware of their responsibilities.

The provider had made available opportunities for relatives and staff to give suggestions about how the service could improve.

Ivydene 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.

The inspection visit took place on 6 October 2016 and was unannounced. The inspection team included an inspector and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information that we held about the service to plan and inform our inspection. This included information that we had received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We also contacted Healthwatch (the consumer champion for health and social care) and the local authority who has funding responsibility for some people living at the home to ask them for their feedback about the service.

We spoke with four people who used the service and with the relatives of three other people. We spoke with the registered manager, the deputy manager, three care staff and a cook. A health care professional was visiting the home when we visited so we spoke with them to gain their feedback on the service offered. We observed staff offering their support to people throughout our visit so that we could understand people's experiences of care.

We looked at the care records of three people who used the service. We also looked at records in relation to people's medicines, health and safety as well as documentation about the management of the service. These included policies and procedures, training records and quality checks that the provider had undertaken. We looked at three staff files to look at how the provider supported their employees and how they had recruited them.

Requires Improvement

Is the service safe?

Our findings

The provider did not always take the appropriate action when suspected or actual abuse took place. For example, we read in one person's care records how they were known to display behaviour towards people that could cause harm. We saw that the provider had measures in place to protect people but these were not always effective because this person had displayed inappropriate behaviour towards five people living at the home over a five month period. Although the registered manager told us that some of the incidents were reported by them directly to a social worker, we found that safeguarding alerts to the local authority and contact with the police had not always occurred. This was not in line with the provider's policy or local safeguarding procedures on protecting people from abuse. This meant that the police and the local authority's safeguarding team were not always notified by the provider as soon as incidents occurred in order to investigate them. The provider agreed that they had not acted in accordance with their or local safeguarding procedures to keep people safe from actual or suspected abuse.

This matter constituted a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to respond to accidents and incidents. However, for some incidents, the provider's forms were not always used to record the details. It was not clear what investigations had taken place to look at ways of reducing such incidents in the future. We saw for one person that they were involved in 13 significant incidents. There was no record to indicate that each incident had been investigated and analysed by the provider. This would have allowed them to make sure risk reduction methods were working and effective to prevent reoccurrences wherever possible. When we spoke with the registered manager about this they said that they did investigate all incidents and they showed us as examples of written reminders to staff to make sure that any equipment people needed to have in place was being used correctly. They told us they would use incident forms to record their findings in the future. For other accidents and incidents, including where people had fallen, staff members completed an incident form. We saw that this detailed the action they had taken including seeking the support of emergency services where this was required. We saw that the registered manager had recorded if they referred significant falls to the local authority or us for further investigation.

The provider had regularly checked the environment and equipment to maintain the safety of people living at the home. However, we found some risks to people's safety that had not always been identified by the provider. We saw that a fire door was cluttered with cleaning equipment and furniture which meant people may not have been able to evacuate easily in the event of an emergency. We spoke with the registered manager about this on the morning of our visit but the items had not been cleared when we left in the afternoon. We mentioned this to the provider who said they would remove the items. We found the courtyard to be unkempt with uneven slabs that would not be safe for people to walk out on their own unsupervised. We also saw that the provider's policy for having bed rails to help people to remain safe when in bed detailed that they should be regularly monitored to make sure they continued to keep people safe. There were no records to confirm these checks had occurred although staff confirmed people were regularly checked. The provider said they would put these checks in place.

People told us they felt safe living at the service and with the care they received. One person said, "Yes, it is a safe place. Nothing really frightens or worries me." Another said, "We do feel safe. I've no real worries being here." Relatives had no concerns about their family members' safety and one told us, "We've never had any safety problems with [person's name] being here."

We saw that the fire detection system, gas systems and electrics were tested in line with recommended guidelines. We saw that there was a potential scald risk to people from some uncovered radiators within the home. This was because some people were at risk of falling and may not have been able to move if they fell against them. The provider showed us records detailing how they had lowered the temperatures of the radiators where they were not covered to reduce the risk. We also saw that some traditional radiators in people's own rooms had been replaced with low surface temperature radiators following our recommendation at the last inspection. This meant that the provider had taken action to reduce risks to people's health and well-being.

The provider had plans in place to ensure the safety of people in the event of an emergency, such as a fire. Staff were able to describe the level of support each person would need to evacuate the building. We also saw that the provider had arrangements in place to provide, for example, emergency accommodation or additional staffing to people should this be necessary. This meant that staff had information available to them should a significant incident have occurred.

Staff members had a policy made available to them by the provider to protect people from abuse. This included guidance on the types of abuse and the action to take should they have concerns about alleged or actual abuse. Staff knew what action to take should they have needed to. One staff member told us, "I'd tell the manager straight away or I'd ring Leicestershire County Council if needed or CQC or the police." We saw that staff received regular training that they found helpful on keeping people safe which meant that staff were aware of their responsibilities.

Risks to people's health and well-being were assessed and reviewed. For one person we saw that they were at risk of injury to their skin. Their assessment included guidance for staff on how to reduce this risk. For instance, staff were directed on the equipment the person required as well as how often the person required assistance to move to keep their skin healthy. We saw that the person's care records showed how often the person had been assisted to move. This was in line with the risk assessment which meant the person was getting the support they required. People felt safe where there were risks to their safety. One person told us, "I can't walk by myself any more so they help me with my frame and into a wheelchair. It's done okay." We saw other regularly reviewed risk assessments that contained guidance for staff to support people to remain safe. For example, where people were at risk of falling and where people showed behaviour that could cause injury to themselves or others. This meant that staff had guidance to help people to remain safe.

People and their relatives felt there were enough staff to help them to remain safe. One person told us, "I think there are enough people at any one time." Another said, "I think there are sufficient people around." Relatives felt that the staffing numbers were appropriate. One commented, "There seems to be enough. I can usually see someone passing [main lounge]." Staff members told us how the registered manager changed their shift patterns and supplied extra staff where necessary to meet the safety needs of people. One staff member said, "At the moment there's enough…The management acknowledge and do give additional staff where needed." On the day of our visit we found there were a sufficient number of staff to meet people's needs safely.

The provider had a recruitment process in place for prospective staff members. This included the provider obtaining two references for each prospective employee and a Disclosure and Barring Service (DBS) check.

The DBS helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. We saw that staff files contained records of these checks. We saw that DBS checks were renewed every three years to check the on-going suitability of staff members. This meant that people were supported by staff who were appropriately verified.

People received their prescribed medicines when they needed them. One person told us, "She [staff member] stays with me when I take my tablet." A relative commented, "They're very good on doing it properly." We observed a staff member offering people their medicines. They did this in ways that followed national medicines guidance such as making sure they recorded the administration as well as storing medicines safely after completing their duties. We looked at ten people's medicine records and found that these were suitably completed and showed where people were offered as and when required medicines such as pain relief. Staff had clear guidance on when they could offer these medicines so that people received a safe amount when required.

Staff had received training to make sure they handled people's medicines safely. The registered manager told us that the competency of staff was due to be checked in the next two months to make sure staff had the required skills and demonstrated safe practice when handling people's medicines. We saw training records that showed staff were trained by a health care professional to undertake a specialist task for a person and their competency for this was checked every twelve months. The provider had made available to staff a medicines policy which gave them guidance on the safe handling, storage and disposal of people's medicines which staff could describe. This meant that staff had the skills and knowledge to safely handle people's medicines.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the provider was working within the principles of the MCA and found that this did not always occur.

Where there were concerns about people's ability to consent to their care, the provider had not undertaken mental capacity assessments to determine their level of understanding for specific decisions. We saw that the provider had a policy on the MCA that was not followed. This stated that mental capacity assessments should be completed. The registered manager agreed that there were 15 people who would not be able to consent to a range of decisions that were made on their behalf. This included decisions in relation to accessing the local area independently and for staff managing their medicines. The provider had not always undertaken decisions in people's best interests involving significant others such as family members and health care professionals where appropriate. We saw that the provider had made some information available to staff on people's capacity to make decisions. In one person's care records we read, '[Person's name] short-term memory is variable'. However, there was no further assessment of how this affected the person's ability to make specific decisions. We found that five people's capacity to consent had not been established where a person displayed inappropriate behaviour towards them. This was in relation to the safeguarding investigation currently being undertaken by the local authority when we inspected. In these ways there were risks that people's human rights were not upheld.

These matters constituted a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were able to consent to their care, they told us they were satisfied that staff asked them for permission to carry out their care. One person told us, "They usually say what they need to do and is it alright." Staff understood the need to ask people for their consent. We heard one staff member say, "[Person's name] shall I pop your pinny on for lunch?"

Staff we spoke with understood the requirements of the MCA. One staff member told us, "People can make some decisions. What to wear and what to eat for example. But can they make the decision to open the door and walk out? I don't think so. We've got to find ways of letting them go out whilst remaining safe." Another said, "You need to give people as much choice as you can and options to help them make their own decisions." We saw that staff had received training in the MCA so that they understood their responsibilities to offer care in line with the Act.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). We saw that the registered manager had made

applications to the 'supervisory body' (the local authority) where they were seeking to deprive people of their liberty. Staff knew when a DoLS application would be required. One staff member told us, "They [people using the service] could think they have the capacity but they could be at risk and not know they are. DoLS is to safeguard them as best as possible."

People's records were not always suitable when monitoring their health. One person was supported by staff to check their blood sugar levels on a daily basis. Whilst this was undertaken regularly, there was no guidance for staff on what would constitute a high or low reading and when medical assistance or advice should be sought. The registered manager told us they would add this to their records so that staff had clear guidance in order to maintain the person's health. We also saw that not all people had emergency grab sheets in place. These are documents that detail people's health and social care needs should a hospital admission be required. The registered manager told us they would make sure these were all in place.

People received support to maintain their health. One person told us, "I've seen the optician once so far and the chiropodist comes in and also cuts my finger nails." A staff member described how they supported people to remain healthy. One said, "We liaise well with the district nurse. One person's skin has started to break down so we got them in today straight away." A visiting health care professional told us, "They are quick to ring if they are worried about anything. The staff come with me to the resident which is helpful and informative." We saw within people's care records that they had regular access to health care professionals where this was required. We saw that some people had recently seen their GP as well as a district nurse where there were concerns about the health of a person's skin. During the handover of information from staff leaving their shift to others coming onto theirs, staff discussed people's changing health needs including where a GP had prescribed new medicines for one person following an appointment. This meant that people's health was supported by staff who sought advice when they had concerns.

People were supported by staff who had received training and had the necessary skills and knowledge. One person told us, "They all seem capable enough." Another said, "I think they're all very good with us." Staff felt that the training they received was suitable in order to offer people effective care. One staff member told us, "The training is good. I'm just doing an end of life course. There's always enough guidance." We saw that staff received regular training in topic areas such as fire awareness, moving and assistance and dementia care. We saw that the registered manager had plans to develop the knowledge of staff including training in first aid for those staff that required an update to their learning.

Staff members received guidance from a manager to make sure they were carrying out their roles and responsibilities effectively. The deputy manager told us that they had received training to support new staff to undertake the Care Certificate when they started to work for the provider. The Care Certificate is a national induction tool, the standards of which providers are expected to follow, to help ensure staff work to the expected requirements within the health and social care sector. We saw records that confirmed staff had received an induction when they started work including topic areas such as the needs of people living at the home and an explanation of fire procedures. Staff told us, and records confirmed, they had regular supervision with a manager. Supervision is a process whereby staff have the opportunity to meet with a manager to receive guidance and feedback on their work. One staff member said, "It's good. Supervision is every two to three months. You can tell them about things and they take them into consideration." We saw that supervision covered topic areas such as suggestions for how staff could improve their practices and future training opportunities. This meant that staff had received regular guidance on how to provide effective support to people.

People were satisfied with the food and drink that was offered to them. One person told us, "Yes, I like the meals. I just have what comes. I think they'd do me a different dish instead if I wanted. I can ask for a snack

at bedtime if I'm still hungry." Another said, "I like the meals, we get plenty to eat." People's relatives commented positively about the food and drink provided to their family members. One said, "He seems to eat well. I know he had seconds of pudding today." We saw that there was a menu displayed about daily food options and staff asked each person for their food choices for the day. People's care records detailed their likes and dislikes and staff were able to describe these. We observed a mealtime in a dining area and found it to be unhurried. People were asked about their food which made the mealtime a pleasant experience where people looked relaxed and satisfied. One staff member was heard to say, "Are you enjoying it ladies? Is it nice?"

Where there were concerns about people's eating and drinking the provider had made written guidance available for staff within people's care records. This had incorporated specialist advice from health care professionals where this had been sought that staff knew about. One person required their meals to be adapted to reduce their risk of choking. A cook explained that a list of people's dietary requirements was on display on the kitchen noticeboard for staff to follow. We saw that this showed people on soft or blended diets, those on supplements or thickeners and included specific guidance for how people needed these to be offered to them. This meant that staff members understood and had information available to them about people's food and drink requirements.

Good

Is the service caring?

Our findings

People felt that staff were kind and considerate. One person told us, "I like them all very much." Another said, "They're all very nice." Relatives spoke in a complimentary way about the approach of staff members. One told us, "The kindness outweighs everything else. Most are lovely." Another said, "They're all lovely girls [staff]." We heard staff speak with people in a caring manner. Staff offered different lunch options to people in a dining room by showing them what was available. They did this at a pace that enabled people to respond without rushing them. This helped people to decide on their meal. We also saw staff sitting with people for a few minutes at a time talking about their childhoods and people looked happy during these times. We heard staff members laughing and joking with the people they supported. People looked happy with this approach by staff and showed that positive relationships had been made.

People's dignity was protected and they were treated with respect when receiving care. One person told us, "I'm in a shared room and they pull the curtains round my friend usually as [person's name] is in bed all the time. They close mine if I'm dressing. The girls [staff] always knock first then come in." We saw that there were locks on bathroom doors to maintain people's dignity and that staff asked people before they carried out care tasks such as assisting them to move. One person became anxious during our visit and staff gently and quietly reassured the person which they responded positively to. We also saw that the provider had recently been awarded the local authority's Dignity in Care award. This recognises good practice when offering care to people.

Staff knew about the people they were supporting. One staff member told us, "Their care plans detail their likes and dislikes. You can ask people as well." Staff were able to describe people's food preferences, how they liked to spend their time as well as their important life events. Family members felt that staff knew their relatives well. One told us, "They know her very well and are very kind." We saw that people were supported in line with their preferences. One person requested to have their lunch in the foyer area of the home and staff told us this was their preference. This meant people received support from staff who knew about things that were important to them.

Staff members understood how to safely store people's private and sensitive information. This was because the provider had made available to them policies and procedures in relation to confidentiality and data protection. Staff understood these requirements and we saw that people's care records were stored securely in the registered manager's office when not in use. We also heard staff speak about people's care requirements discreetly and in ways that protected their confidentiality.

People were involved in decisions about their care wherever possible. One person told us, "I decide what I want to do in the day and what to watch on television. The girls come and fetch me for a shower." Another said, "I decide my 8pm bed times and if I want a drink but they do a lot of the rest." We saw that staff encouraged people to be involved in making decisions. We heard staff say comments such as "Shall we take this bib off now?", "Is that alright? Do you want to help me fold it now?" and, "What would you like to drink, a hot or cold drink? Would you like squash or milk?" Staff respected the choices that people made. This meant that where possible, people were involved in making decisions about their care.

Where people required additional support to make decisions and be involved in the planning of their care, we saw that the provider had made information on advocacy services available to them. An advocate is a trained professional who can support people to speak up for themselves. The registered manager told us that two people had the involvement of an advocate to make sure their care was suitable for them. This meant that people had access to additional support, should they require it, to help them make decisions.

People were supported to be as independent as they wanted to be. One person told us, "I shave myself still and choose what to wear, when they get things out for me." A relative commented on how staff members encouraged the independence of their family member. They said, "She can just about walk still and sometimes with an escort." A staff member elaborated and told us how they encouraged the person to try taking bigger steps when they walked instead of shuffling their feet which worked well to maintain their mobility. We saw staff asking people to make their own decisions in relation to activities and food when we visited. We also saw within people's care records that their independence skills were recorded so that staff had information about people's required level of support from staff members. This meant that people were supported to retain their skills and level of independence.

People's families and friends were able to visit without undue restriction. One person told us, "My family can come and see me any day." Family members commented, "I was told I could come any time to visit Mum. I'm always welcomed and get a drink." and, "I call in whenever I'm passing". This meant that the provider enabled relationships that were important to people to be maintained.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. We were told how some people had to wait for care to be delivered, or did not get all of the necessary support to meet their needs. We observed that when one person, who was often confused and forgetful, was given their lunch they fell asleep. There was no encouragement from staff for over 20 minutes to eat their meal. One relative said, "I think there's enough on duty [staff] but not often in this room [a lounge] in the day. I've sat here before for two hours with no-one else with them. It's bad supervision." Other relatives felt that staffing numbers were adequate but that their family members were often left without the prompting and support they required. A relative commented, "[Person's name] can feed herself. I think she needs more help and encouragement to eat more than she does if she's left to it." Another said, "[Person's name] gets drinks but hot ones can go cold if they don't encourage and remind them."

We observed that staff members were not routinely based in either lounge during the day to observe people or to offer their help or support. We saw that staff occasionally entered to ask if people needed anything or to bring in a drink or sit and chat with them for a short period of time. However, some people were sat in the lounges with little or no support from staff for significant periods of time. We were told of other instances where people received responsive care. One person told us, "They moved me to the downstairs room as I couldn't manage the stairs and using the lift." Staff described how they adapted their approach to the person they were offering support to and said, "You can't rush people, they can be slow but you go at their own pace." In these ways people did not always receive consistently responsive care.

The provider had not adapted the environment to be responsive to people living with dementia. We saw that most people were living with dementia. We found that signs around the home were not in place to aid people's orientation. Most bedroom doors did not have a picture of the person so that they could identify their own room and signs for locating bathrooms and the lift were not in place. We saw that national good practice in relation to dementia care had not been incorporated into the décor within the home. Different areas of the home were not clearly identified to help people know where they were. We discussed this with the registered manager and provider who said they would consider our feedback. We did see that the provider had considered how they displayed some information to help people to make choices. For example, we saw that the daily menu was displayed on a noticeboard using pictures.

People and their relatives felt that there were not enough activities offered to them. People's comments included, "There's nothing much to do usually. I don't get to sit out either. I used to do all my own gardening." and, "I look at books a lot. I don't go outside." People and staff told us that there was no ramp for the step at a rear door to gain access to the outside secure courtyard. One staff member commented it was difficult to use this door if someone used a wheelchair. The provider said they would consider this feedback when we discussed it with them.

Relatives' comments about the activities offered to their family members included, "[Person's name] spends their day just sitting here in the dining room all day.", "I worry that she does get bored. She just sits in here [bottom lounge] most of the day. They have a singalong now and then. She used to love her garden or to

read the bible. They used to have a church service here but not now." and, "I could say that he doesn't get enough stimulation…I think he gets left on his own for long spells." On the day of our visit there was a singer who had been pre-booked. We saw staff encouraging people to join this activity regardless of their ability to participate and one staff member invited a person to dance. We saw there was lots of laughter and joking and people enjoyed this activity. We also saw an activity timetable on display for people that detailed several planned activities each week including exercise to music and arts and crafts sessions. During our visit we saw staff spend some time with people on a one-to-one basis discussing things that were important to them and reminiscing about their past. However, we also observed several people who were often very confused siting on their own for long periods of time in the same lounge or armchair for much of the time we were present without staff enquiring if they wanted to participate in an activity. We spoke with the registered manager about the feedback we received. They told us they were working hard to improve the activities on offer and we saw that they had placed a note on the noticeboard asking family members for activity ideas.

The provider carried out pre-admission assessments before people moved into the home. These were important so that the provider could be sure they could meet people's needs. We saw these in place within people's care records that detailed how the home planned to meet their care requirements. These were then used to develop individual care plans for each person that gave staff guidance on their preferences for how their care should be carried out.

People's care plans were centred around them and focused on them as individuals. They contained information about their likes, dislikes and routines that were important to them. We saw 'This is me' documents that detailed people's personal histories. This was important as staff can use this information to engage in conversation with people. For one person we read how the company of others was important to them and we saw them sitting with people when we visited. For another person we read detailed information about their mouth care routine. We discussed with the registered manager that some areas of people's care plans did not always contain specific details about people's preferences. They told us that staff were working in person-centred ways but this was not always recorded. For example, one person was supported to complete a book about their memories which we saw. This was not referenced in the person's care plan. We found that staff had a thorough knowledge of people's preferences which showed this was a recording issue. The registered manager told us they would look at the recorded information when they next reviewed people's care plans to make sure staff had all of the required information available to them to offer responsive care.

People or their representatives contributed to the planning and review of their care. Relatives told us that the role of a keyworker was useful to support people to share with staff how they preferred their care to be undertaken as well as sharing information with them. A keyworker is a staff member who supports a particular person to make sure that they have the things that they need and to work closely with them to make sure they are satisfied with the service offered. Relatives told us how they had contributed to their family members' planning and review of their care. One said, "My dad comes in regularly and to do any paperwork. He sees her keyworker too." Another told us, "I have a chat to her keyworker three to four times a month who will always tell me things. I'm very happy with the system." Staff told us, and care records confirmed, that people's care needs were reviewed by the provider every month so that they had up to date information when offering care to people. They said that people's contribution was not always recorded but they would sit with people where they understood the process and consult with them. This meant that the provider gave people or their representatives opportunities for them to contribute to the planning and review of their care.

People's relatives knew how to make a complaint should they have needed to. One relative told us how they had approached the registered manager to raise a concern they had. Another relative confirmed they knew

how to complain and told us, "I've no real worries about him. They give them the time here. You can have posher places but not the care. I'm happy with it overall. It's not the smartest but the heart is there." Staff told us that most people living at the home would not be able to complain for themselves. They described how they spoke up for people on their behalf when this was necessary. One staff member said, "You get to know people's gripes and dislikes especially those who wouldn't be able to complain. When I notice changes I speak to the manager." We saw that the provider displayed their complaints procedure which informed people and their visitors of what action they would take should a complaint be received. We found that this procedure detailed other agencies such as CQC that people or their visitors could share their concerns with should they have needed to.

Requires Improvement

Is the service well-led?

Our findings

The provider was not meeting the requirements of their registration with CQC. This was because the provider did not always submit statutory notifications to us following significant incidents at the home. Statutory notifications contain information relating to significant events that the provider must send to us as required by law. We had not been notified about 12 incidents of suspected or actual abuse. The registered manager agreed that these were not submitted and they confirmed they knew of this requirement. This meant that the service was not always informing us about significant events at the service.

This matter constituted a breach of Regulation 18: Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that providers display their latest CQC rating conspicuously within the home and on their website. This is so that people and others seeking information about the service can see our current judgment. We found that the provider had not displayed their current rating from us following our last visit either on their website or within the home. The provider told us they were not aware of this requirement and said they would take action to display our rating.

This matter constituted a breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's quality checks of the service were not effective in identifying the concerns that we found during our visit. Their range of checks did not highlight that people's mental capacity had not been assessed for specific decisions, that significant incidents had not always been reported in line with local safeguarding guidance and that registration requirements were not always met.

The provider had other effective checks in place to routinely monitor the quality of the service. A staff member told us, "The manager observed us, it's for our appraisal. They do it discretely and they give us feedback for how we can improve where we need to." We saw that regular audits had taken place in the areas of checking the cleanliness of the home, falls that people experienced and maintenance. We saw that where the provider had identified areas for improvement, or where additional support or resources were required, actions were usually documented within the audits and signed off once completed. We saw that a recent cleaning audit identified actions such as the cleaning of carpets. This was not marked as complete. We spoke with the registered manager about this who told us they would review the audit to make sure that all actions had been undertaken. The registered manager told us that medicines audits were completed during 2016 but not recorded. They told us a member of staff had been given this responsibility during 2016 and they would make sure that these audits were recorded in the future to show where improvements were needed where required. This meant that the provider had some arrangements in place to check the quality of the service.

People and their relatives were satisfied with how the service was run and with the approach of the registered manager. One person told us, "I see her [registered manager] in and out. She will talk when she's

got the time." A relative commented, "I see them both [registered manager and deputy manager] about a lot and find them very approachable." Another relative commented, "More carers in the bottom lounge. Otherwise I'm very happy with the place." People and their relatives felt they could speak with the registered manager should they need to and that they would listen to their concerns. We read many compliments that had been received by the provider from the local authority and people's families stating their satisfaction with the caring approach of staff.

Staff were supported by the registered manager and there were opportunities to offer their feedback. One staff member told us, "If I had any problems I'd go to any of them [managers]. I can if I want to and I can speak up." We saw that staff received regular supervision to receive and give feedback on their work. We also saw that the registered manager was available to staff during our visit answering questions that they raised as well as offering guidance on people's support requirements. Staff meetings regularly occurred and covered topic areas such as reminders to staff about procedures and opportunities for them to raise questions and to give suggestions for improvements to the service. In these ways staff received guidance on their work and the registered manager had arrangements in place to routinely check the values and attitudes of staff members to make sure they provided good quality care to people.

There were opportunities for family members to give feedback to the provider about the quality of the service. We saw that the provider had sent them questionnaires during 2016. A relative told us, "I've just been given one recently. We do about twice a year I think." We saw some of the returned questionnaires that the registered manager was currently analysing. Most of the comments we read were positive and complimentary of the service. There were ideas for improvement given including requests for more activities and suggestions for upgrading the home. The registered manager told us they would tell people about what action they were going to take as a result of the responses. We also saw 'A message to the manager' cards within the home for people or their visitors to complete should they have feedback about the quality of the service. This meant the provider had processes in place to routinely seek feedback about ways to improve the quality of the service.

Staff were aware of their responsibilities. This was because the provider had made a range of policies and procedures available to staff which they knew about. This included a whistleblowing procedure. A 'whistle-blower' is a staff member who exposes poor quality care or practice within an organisation. Staff could describe the action they would take should they have concerns. One staff member told us, "It's about talking to someone in confidence and they will help you." We found that the provider's whistleblowing policy had contact details of organisations available for staff who they could raise their concerns with should they have needed to, such as the public concern at work helpline.

The provider had clear aims and objectives for the service that staff could describe. Staff told us how they strove to promote people's independence and to offer care that was dignified and in ways that were important to people. We saw staff following the provider's aims when we visited. This meant that staff knew about the aims and objectives of the service and offered support in line with these.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not always notify without delay significant events to Care Quality Commission as required in the carrying on of a regulated activity. Regulation 18 (1) (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to their care and treatment was not always considered in line with the Mental Capacity Act 2005. Regulation 13 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems to protect people from allegations of or actual abuse were not always followed. Regulation 13 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not display on their website or within the service the most recent rating by Care Quality Commission. Regulation 20A (2,3).