

Tanglewood (Lincolnshire) Limited

Tanglewood Care Home with Nursing

Inspection report

36 Louth Road
Horncastle
Lincolnshire
LN9 5EN
Tel: 01507 527265

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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



Overall summary

This report was the subject of a judicial review challenge in the High Court for which permission was granted by Mr Justice Kerr on 18 December 2015. In light of the recent report for the inspection on 16 February 2016 the provider Tanglewood (Lincolnshire) Limited and the Care Quality Commission have agreed that it is no longer necessary for the High Court to determine the judicial review.

We inspected Tanglewood Care Home with Nursing on 20 August 2015. This was an unannounced inspection. The service provides care and support for up to 55 people. When we undertook our inspection there were 45 people living at the home and five in self-contained bungalows within the grounds.

Summary of findings

People living at the home were older people. Some people required more assistance either because of physical illnesses or because they were experiencing memory loss. The home also provides end of life care.

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

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report, regarding medicines, how to implement the Mental Capacity Act 2005 and care plans.

We found that the deployment of staff meant that at times staff required more time to ensure the needs of people could be met.

Staff were unaware of the implications for administration for some medicines. Systems were not in place to ensure medicines were stored correctly and safe to use and storage was not stock controlled.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered

necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of our inspection there was no-one subject to an authorised restriction. However, the provider had submitted 23 applications to the local authority to clarify whether people should have their liberty restricted. Staff did not always act in accordance with the MCA 2005 as they were unsure of how to implement it correctly.

We found that people's health care needs were assessed, and care planned through the use of a care plan. People or their advocates were not involved in the planning of their care and had not always agreed to the care provided. The information and guidance provided to staff in the care plans was clear, but not updated. This could result in people's current needs not being met. Risk assessments were not in place for people in the event of a fire, which could put them at risk of harm.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives.

People had a choice of meals, snacks and drinks. And meals could be taken in dining rooms, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Checks were made to ensure the home was a safe place to live.

The deployment of staff meant staff needed to ensure the manager was aware of times when it was difficult to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were not stored safely. Record keeping and stock control of medicines was poor. Staff were not aware of the risks of taking some medicines.

Requires improvement



Is the service effective?

The service was not consistently effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards (DoLS) and the key requirements of the Mental Capacity Act 2005 were not always understood by staff.

Staff were able to identify people's needs and recorded the effectiveness of any treatment and care given.

Requires improvement



Is the service caring?

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Good



Is the service responsive?

The service was not consistently responsive.

People's care was not planned and reviewed on a regular basis with them.

Activities were planned into each day, but there was little stimulation for those with dementia and for people to pursue individual hobbies and interests.

People knew how to make concerns known and felt assured anything raised would be investigated in a confidential manner.

Requires improvement



Summary of findings

Is the service well-led?

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

The provider sought to improve quality by undertaking audits and surveys however, assurance that actions had been taken as a result of these was not always available.

Requires improvement



Tanglewood Care Home with Nursing

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 20 August 2015 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We also spoke with other health care professionals during our visit.

During our inspection, we spoke with seven people who lived at the service, five relatives, and five members of the care staff, two activities co-ordinators, a cook, the company trainer, the area manager for the provider and the registered manager. We also observed how care and support was provided to people.

We looked at seven people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff rotas, audit reports and records related to medicines management.

Is the service safe?

Our findings

We observed two staff administering medicines safely by ensuring the person understands what they were taking and waiting for the person until they had taken them. Staff were observed giving advice to people about their medicines. Staff knew when questioned which medicines people had been prescribed and when they were due to be taken. We observed two staff administering medicines at 2pm and 2.20pm. These were for the medicines, which were detailed to be given at 12pm. Staff could not explain why these were given later than prescribed. They sat with each person, explained what they were taking and waited to ensure the medicines had been taken.

Medicines were kept in two locked areas. Each trolley and cupboard was clean and tidy. However, no temperatures were recorded to ensure the medicines were stored in suitable conditions. A thermometer had been provided but staff did not record the room temperatures only the medicines refrigerators. In one storage area the refrigerator temperatures were only recorded spasmodically. This would ensure the stored medicines were safe to use if recorded regularly. A system was in place that staff should put the date on certain medicines when they were opened, to ensure the expiry date could be adhered to. We found several bottles of liquids where this had not happened.

We looked at 17 people's medicine administration records (MARS) and found they had been completed consistently. However we found on three MARS that staff were not aware of the risks for people in taking certain medicines. For example the prescription stated a medicine was to be taken at night, but was being given at tea-time. There was no agreement in the person's care plan that this had been discussed with the GP. There were special instructions required for the giving of one medicine, which staff were not aware of and we could not find any instructions to staff on how to administer this medicine. However, staff could not tell us whether this medicine had been given on an empty stomach as the instructions indicated. On two MARS staff told us the medicines were no longer in use by those people, but they had not been removed from the trolleys and there was no indication why they had been stopped.

These matters were a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that usually their needs were being met. However there were times when this was not so and they had raised this with the manager. One person said, "You see I need two people to assist me and so that's a bit more tricky for them as it takes two staff off the floor. I have had words with [named staff member] in the past about it because it isn't good. Anyway, last night [named person] had a fall and I couldn't help her of course because of my disability. So I rang my bell and they came in about 2 minutes, which was very good. My [named person] wasn't injured thank goodness; [named person] lost their balance." Another person said, "They don't seem to be using as many agency staff now as they did, which is better, because the agency lot don't get to know you or know about you the same as the regular staff." Another relative said, "They appear short staffed. They could do better I think."

Staff told us there were times when staffing levels were challenging. One person said, "I'm used to it, but it is harder now. We can always do with an extra pair of hands, it gets brought up, but nothing is done." Another staff member said, "It's a bit rushed each day. It has been brought up." Another staff member said, "When we are fully staffed it's alright." Although there were enough staff to meet people's needs these were not all deployed effectively at busy times of day.

We saw on the staff rota the numbers of staff required reflected the staff on duty that day, but there were several changes to the rota and requests for cover for other days, so the provider would have to change the rota to accommodate shortfalls. The rota was changed to reflect times when arrangements needed to be made to cover sickness and holidays. The rota also identified how many people were required for escort duties and staff told us they did extra shifts on those days. Staff told us they were not involved in discussions about the levels of staffing required. The registered manager told us they tried not to use agency staff, but sometimes this was inevitable if their own staff were not available. The registered manager told us they calculated the staffing levels, although at the time of the inspection they were unable to demonstrate how the staffing levels had been calculated. The provider told us after the inspection that staffing levels were higher than those recommended in an independent market review, however they did not demonstrate how the particular needs of the individuals at this service had been considered in allocating staffing levels. We saw that staff

Is the service safe?

had to work in a task focused way to meet people's basic needs, for example people were offered toilet facilities before lunch to minimise disruption during mealtimes. Although this minimised disruption for the staff and people they supported while they were having their lunch, this uniform approach did not take into account individuals' needs and preferences.

People told us they felt safe living at the home. The people related well with the staff and the staff knew everything about them. One person said, "Yes I feel safe. We bought a machine to assist me standing because it helps me. They didn't have the specialist one I needed, so I purchased it." This was the personal wish of the person concerned. Another person said, "Yes, I feel safe, I have cot sides on my bed and I can reach my buzzer at all times if I need to call them."

Staff were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the senior staff would take the right route to safeguard people. Staff said they had received training in how to maintain the safety of people who spent time in the service. The training records confirmed that all staff had received safeguarding training in 2014 and 2015.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns. The last review was in June 2015. This ensured any changes to

practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through meetings when actions needed to be revised.

To ensure people's safety was maintained a number of risk assessments were completed for each person and people had been supported to take risks. For example, where people had a series of falls the people's ability to walk unaided had been assessed. Where necessary the falls co-ordinator from the local hospital had been contacted for advice. Where people did not have foot rests on their wheel chairs, risk assessments had been completed. This was to see if they were safe without them. Staff knew the reasons behind the decisions and were helping the people to use the wheel chairs safely. Other risk assessments were in place for the risk of pressure ulcers and malnutrition. These had been reviewed at least monthly.

On the day of our inspection, plans were not in available for each person in the event of an evacuation of the building and staff we spoke with were unable to tell us where they would locate them. After the inspection the provider told us these were in place and were located in the reception area however, they were not there on the day we visited. These should give details of how people would respond to a fire alarm and how they required to be moved. This was a concern for people living on the first floor, most of who had some form of memory loss, as an emergency evacuation would be by the stairs. There was a risk that, if an incident had occurred, staff would not have had the information to hand to remove people from the building safely. A plan identified to staff what they should do if utilities and other equipment failed and staff knew how to access this document in the event of an emergency.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

Some staff were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. Other staff did understand when a formal assessment of people's mental capacity would be required or how to record people's consent to treatment. Most staff said they would leave decisions such as those to senior staff, but were unaware of how important their own input was to the process, as they looked after people each day and would have an understanding of people's needs and preferences to support the process of making best interest decisions. All staff regardless of their position should act in accordance with the MCA 2005 and be aware of ways in which people could consent to aspects of their care and treatment. The majority of staff had undertaken training in the Mental Capacity Act 2005 in 2014 and 2015. The rest had this planned into their training programme for 2015.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. The care plans evidenced that people's capacity had been assessed, but these were generic assessments made on everyone within the service. They did not take into consideration the people's individual needs or how their condition impacted on other health and well-being factors such as maintaining a balanced diet and maintaining personal hygiene. Other parts of the care plans gave guidance to staff on how people liked to move around the building and if they required a shower or bath. The handover sheet used by staff to identify the needs and mental capacity of people stated that 23 people had DoLS in place. This was clarified by the registered manager, that 23 applications had been made. They were waiting on the decision from the local

authority about those applications to confirm whether the authorising body agreed with the assessments. Processes had been put in place by the provider to ensure people were safe until the authorising body finalised the applications.

Relatives did know about care plans. Where the care plans had stated people could not make decisions for themselves staff had not always recorded the involvement of families or other advocates. For example, where a wheelchair had been changed from a self-propelling one to one to be pushed. This information had not been passed on. The wishes and consent of the person had not been recorded during the assessment process. This person told us this had impacted on their independence as they were no longer able to move around the home unassisted.

These matters were a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

One staff member told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as assessing risks and record keeping. They told us it had been suitable for their needs.

Staff said they had completed training in topics such as basic food hygiene and manual handling. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. The training records were split into two. One for mandatory training, which all staff had to complete and one for best practice, which staff would be asked to do if possible. Some staff had completed training in particular topics such as end of life care and managing behaviours of people. This ensured the staff had the relevant training to meet people's specific needs at this time.

Staff told us they had training sessions in the home, but could also attend courses in the community. One staff member told us they had attended a dementia awareness session with people from other homes. A staff member said, "This was a really good course." Staff told us they were encouraged to ask for training which suited their needs and interests, such as taking people's blood for analysis. A full time trainer was in position within the company who delivered most of the training locally.

Is the service effective?

Nursing staff also had to complete certain clinical skills, such as wound care, verification of death and male catheterisation. The analysis of nurses' clinical skills had been completed in August 2015 and any gaps identified in the staff skills base were being proactively addressed.

We saw the supervision planner for 2015. This gave the dates of when supervision sessions had taken place. Staff confirmed these had occurred. Staff told us they could express their views during supervision and felt their opinions were valued. The registered manager informed us they aimed for three formal sessions each year, but this depended on staff needs and skills. This was in line with the supervision policy.

Some people told us that the food was fair but not always varied, but the majority felt the food was good. One person said, "It's ok, basic." Another person said, "I get enough to eat." A relative told us, "My [named relative] is on a [special diet] and they seem to manage that ok for her."

We observed the lunchtime meal in two dining rooms and people having meals in their rooms. We saw the meals were presented well and where required special aids such as plate guards and cutlery were in use. They had been placed on plates before being presented at the tables. However, there was little social interaction between staff and people eating their meals. Staff served the meals, but did not always ensure people had hot or cold drinks of their choice. We had observed people being offered hot and cold drinks throughout the day. Where staff were having difficulty assisting one person, another staff member intervened and the person had a balanced meal. Staff asked people if they required meals cut up or extra help. We did not see any menus on display either written or pictorial. This meant people could not refer to what was on offer that day and to remind themselves of their choices. We did see menus in the kitchen area but only in a written format. There were no pictorial menus for those who could not read or understand written English.

Those people who required assistance to eat their meal were given them in their bedroom areas or in a separate dining area. We heard staff explaining what was on plates, for those with limited sight and giving encouragement. We saw the daily records in the kitchen when staff had asked people about their daily menu choices. The records stated what people's appetite was like on admission, their likes and dislikes and where they preferred to eat their meals.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their weight and when a person required a softer diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. Staff told us each person's dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans.

Staff understood what to do if people's needs changed and how they would help someone to prevent pressure damage to their skin, for example. We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to walk with a stick to help their mobility. We heard staff speaking with relatives, after obtaining people's permission, about hospital visits and GP appointments.

Health professionals told us staff made referrals to them when people's needs changed. They said staff were knowledgeable about people and could follow instructions. Staff knew how to obtain advice from a number of health care professionals such as continence advisors and palliative care nurses for those people at the end of their life.

Is the service caring?

Our findings

People told us they liked the staff and they were confident staff would give them good care. One person said, “Yes, they do care in their way you know.” Another person said, “They are lovely boys and girls. I feel like I’m cared for here.” A relative said, “They are very good when they eventually get to the patient.” Another relative said, “[Named relative] seems happy enough here.”

All the staff approached people in a kindly, non-patronising manner. They were patient with people when they were attending to their needs. For example, one person was distressed about something they were thinking about, which a staff member noticed. They approached the person and calmed them down whilst answering their questions.

We observed staff ensuring people understood what care and treatment was going to be delivered before commencing a task, such as helping with a bath, ensuring people knew when treatments were about to commence and assisting each other to turn some-one in bed.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, when some-one did not want to dress for the day. Their wishes were respected. Another person had difficulty expressing their needs, but staff waited patiently until the person finished each sentence.

Staff knew the people they were caring for and supporting. They told us about people’s likes and dislikes. For example, when they liked to get up in the morning and when they liked to dress or remain in bed. This was confirmed in the care plans. Practical action was taken when people were

distressed. We observed care staff and ancillary staff responding to people who were worried and anxious. If they could not answer a person’s query the registered manager, nurse or team leader was called to assess each situation. One person was anxious about visitors coming and they were reassured as the time which had been stated by the relatives.

Staff responded when people said they had physical pain or discomfort. When someone said they felt unwell, staff gently asked questions and the person was taken to one side. When the emergency call bell was sounded we saw staff respond to the person’s need. As soon as possible the minimum amount of staff stayed with the person, not to frighten and worry them. People told us they knew how to press their call bells and staff usually responded quickly. One person said, “The buzzer thing varies. The timing to respond has improved.”

Relatives we spoke with said they were able to visit their family member when they wanted. They said there was no restriction on the times they could visit the home. One person said, “My family are large so I always have visitors. It’s nice they can come any time.” Staff were seen offering refreshment to visitors.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display.

People had access to several sitting room areas, two dining rooms, and quiet areas in corridors and an enclosed garden area. We observed staff asking people where they would like to be, if they required assistance to move about the building. Staff ensured each person was comfortable, had a call bell to hand and had all they required for a while.

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs and this was in the form of conversation. People who used the service did not know about their care plans or had been involved in the planning of their reviews. Care plans were kept as paper records and kept securely. One person told us staff obtained the advice of other health and social care professionals when required.

The relatives of one person had reported to staff when people's equipment to help them see and hear had been lost, this had not been recorded. The care plans had not been reviewed to reflect that this person might have increased difficulty seeing or hearing or how this person would be supported until replacements had been arranged.

People who used the service told us that generally their needs were being met. However, two people said they had to ask staff for updates on their treatment, rather than information being offered. The care plans did not reflect the actions staff had taken to resolve problems for people and how information was used to inform decisions made with and for people. We did observe staff responding to people's needs throughout the day and consulting with each other as to the most appropriate form of treatment or care. This was then discussed with each individual.

When people required the support of equipment to assist their well-being care plans did not show how people had been involved in decisions regarding the use of equipment. For example, where someone spent some time in bed they had been assessed for the risk of falls. However, we saw bed rails in place. We did not see the assessment for their use or who had given permission for them to be used. The care plan stated the person could not make decisions for themselves but a best interest decision process had not been followed. This could result in restraint being used unnecessarily.

Initial information in people's care plans stated their particular dietary needs were being met. However, in one care plan the initial information stated a person had diabetes. In the summary overview which had been reviewed in July 2015 by staff, diabetes was not mentioned and there was no care plan around the risk of having this condition. Staff had irregularly written in the monitoring

sheets of the person's condition. It would not be clear in the care plan why blood sugars were being monitored. This could result in the person becoming unwell and staff being unable to respond to that person's needs.

Where people had a history of urinary problems this was not reflected in the care plans. Therefore staff may not be aware of early signs of infection and retention or which other health care professionals may be involved. In one care plan the catheter monitoring chart could not be found by staff on the day of our inspection, although they told us one was used. This was a risk that they could not pass on to the community staff how well the person was for three days. Where people had behaviour which could be challenging to others, care was not reviewed to ensure that it met their individual needs. While staff kept a chart of their behaviour, it was not clear how this record was used to inform and evaluate people's care plans as just listed events. There were two incidents where a person challenged another but the records did not say what action had been taken to prevent a recurrence of this and minimise the risk.

We looked at the care plans of three people who staff told us had dementia. The specific types of dementia were not documented and therefore their presentation had not been considered as part of the formal assessment process. There was no monitoring of their cognitive functioning and how they were responding to changes or declining. This meant that people were at risk of not receiving care that was centred on their individual needs.

We saw some Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) forms were out of date. There was no reviewing process in place to ensure review dates were adhered to, timescales for those put in place in hospital were adhered to, assessments about mental capacity and consent of people and that all the information on the forms had been correctly recorded. Although it is the responsibility of the medical practitioner to complete the form correctly, the provider has a responsibility to keep the medical practitioner informed of any changes, in case they want to review the original decision. If a form is incorrect and a person's needs have changed this could result in other health professionals not accepting the form as being valid. For example on one form it stated the person was in a coma. We observed this person having a drink.

Is the service responsive?

These matters were a breach of Regulation 9 (3) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care and wrote on pre-written handover sheets. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten.

People told us there was an opportunity to join in group events but staff would respect their wishes if they did not want to take part. This was not recorded in the care plans, but activities co-coordinators kept records of who had attended group events. Some records showed when people had one to one activities. However the only type of one to one which was listed was, "Sat and chatted to [named person]." There were no records to support that people were interested or that their individual hobbies and interests had been explored with them. This could result in them not having enough stimulation to occupy their days.

People told us about some of the group activities. People said they enjoyed dominoes and bingo. We observed a volunteer assisting 10 people at an art class and in the morning there had been an exercise event with 12 people. Staff told us there was a monthly Christian service.

Although the two activities co-ordinators had not received any specific training in their roles or in dementia, they had accessed the internet to find out for themselves about different types of dementia and what to do. Relatives told us they had seen activities taking place. And described sing-a long. One relative said, "They get us to sing which is good." Staff were getting ready for their summer fete in two days.

People told us they were happy to make a complaint if necessary and felt their views would be respected. No-one we spoke with had made a formal complaint since their admission. People knew all the staff names and told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display. The complaints log detailed one formal complaint the manager had dealt with since our last visit. It recorded the details of the investigation but this was still in progress so there was no outcome.

The area of the home where the majority of people lived that had dementia was not dementia friendly. Although there were signs on doors of areas such as the lounge and dining room, there was no directional signposting to assist them to find their way there. There was no personalisation around the doors to enable them to identify their rooms, which can be difficult for people who suffer from memory loss.

Is the service well-led?

Our findings

There was a registered manager in post. People told us they could express their views to the registered manager and other staff and felt their opinions were valued in the running of the home. Relatives told us if they had issues in the past they had raised them with the manager.

People who lived at the home and relatives completed questionnaires about the quality of service being received. We saw the results of the questionnaires for 2014. This was an annual survey and the one for 2015 had only recently been sent out. The results for 2014 were mainly positive. The questionnaires had been sent to people who used the service, health and social care professionals in the community and relatives. They covered areas such as, customer satisfaction, complaints, activities, dignity and respect and meals. However the analysis of the survey results did not demonstrate how the provider was using it to effectively take action in response to issues that had been raised.

There were meetings for people who live in the home and relatives. We looked at the minutes for meetings in September 2014 and March 2015 for people who use the service. We also looked at minutes of meetings for relatives for February 2014 and September 2014. We were sent after the meeting the minutes of the meeting with relatives, but this had been titled for residents for 19 August 2015. Relatives told us they had attended that meeting, not people who used the service. Some relatives told us they did not know about the meeting, but would have attended. The meetings covered a variety of topics such as activities, laundry, and infection control. People had been given opportunity to express their views and where necessary actions had been commenced; such as asking relatives to label clothing. People told us it was an effective way of voicing their concerns and knowing about the progress of the company. The provider was being proactive in setting up meetings and being open to suggestions from people who used the service and relatives.

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of staff meetings for June 2015 and August 2015 for nurses and for August 2015 for care staff. Each meeting had a variety of topics which staff had discussed, such as, care plan reviews, supervision and working at night. This

ensured staff were kept up to date with events. There was no indication of when items had been actioned and completed when topics had been raised to assure the provider that these were being addressed.

Staff told us they worked well as a team. One staff member said, "I love working with people with dementia." Another staff member said, "We all work well to assist people with their needs." They told us the registered manager was approachable.

There was sufficient evidence to show the home manager had completed audits to test the quality of the service. Where actions were required some of these had been clearly identified and signed when completed. An example completed in June 2015 included details of a call bell audit. This had shown poor times so methods were put in place to ensure call bells were answered more promptly and the provider had acted quickly in response to the audit results. However, issues had been raised in the medicines audit for June 2015, but there were no records to show these had been completed. Also, the kitchen audit for July 2015 identified poor ventilation, but although this was subsequently resolved, this was not evident from the auditing process. Accidents and incidents were analysed monthly. Staff told us any changes to practice were completed immediately for people and noted in their care plans which we saw in the records. Whilst walking around the home during the visit the inspectors noted a malodorous smell on the first floor. This was predominately in one room and near the landing area. When notified to staff this was dealt with before the end of our visit. Relatives told us this was not the first time this had happened. One relative said, "The odour upstairs is terrible. It knocks you off your feet, especially at the top of the stairs near the toilets." Staff told us this was a long term problem and mainly centred on the care needs of one individual. This was not identified in any audits and we did not see evidence to support, that if a long term problem, how this was being managed.

A company representative visited the home at least weekly. They produced a monthly report. We saw the ones for March 2015, May 2015 and August 2015. They covered issues such as care plans, complaints and staffing. Where required actions were noted and reviewed on the next visit.

People's care records and staff personal records were stored securely which meant people could be assured that

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their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	How the regulation was not being met: Staff did not understand about all the medicines they were giving and there was poor stock control and storage. Regulation 12 (2) (g)
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Diagnostic and screening procedures	How the regulation was not being met: Care plans were not updated and people or their advocates were not involved in the planning of their care. Regulation 9 (3) (c) (d) (e)
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
Diagnostic and screening procedures	How the regulation was not being met: Staff were not adhering to the guidance for the implementation of the Mental Capacity Act 2005. Regulation 11 (3)
Treatment of disease, disorder or injury	