Headroomgate Limited

Headroomgate Nursing 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 11 & 16 May 2016 and was unannounced.

Headroomgate Nursing Home provides accommodation for up to 19 people who have nursing needs. The home is situated close to St Annes town centre and is a large corner property with garden and paved areas around the building. There are three floors, two of which have lift access, two lounges and dining areas. Some bedrooms have an en-suite facilities.

This was the first inspection of the service since it was registered with the Commission on 31/07/2015.

At the time of the inspection there were 18 people who used the service.

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.

At the time of the inspection the manager's registration with the Commission had been cancelled. We were advised that the provider was planning to appoint a new manager who would be put forward for registration following their appointment. In the interim, the previously registered manager was continuing to oversee the day to day running of the service.

Risks to the health, safety and wellbeing of people who used the service were assessed and care plans were developed to provide staff with guidance about how to support people safely. These included moving and handling care plans. We found that all staff had received training in safe moving and handling. However, we observed two staff members, on two separate occasions, use moving and handling techniques which were not in accordance with the person's care plan guidance or general good practice.

People we talked with spoke highly of care workers who they described as 'kind' and 'caring'. People felt they were cared for in a manner that promoted their privacy and dignity. However, we observed that not all care workers were mindful of respecting people's privacy and dignity at all times.

Personal Emergency Evacuation Plans (PEEPs) were in place for each person who used the service. However, not all those viewed contained person centred information. We made a recommendation that all PEEPs be reviewed to ensure they provide individualised guidance about the support each person would require to evacuate the home in an emergency.

There were generally safe systems in place to manage people's medicines. This helped to protect their health and wellbeing. However, we made a recommendation that information included in records relating to medicines administration be improved to help ensure people get their medicines at the correct times.

Some good examples of person centred care planning were seen. However, other examples were found where more detailed information in care plans would have been beneficial. We made a recommendation about this.

There was a training programme in place to help equip staff with the skills to carry out their roles effectively. However, in light of some of our observations, we made a recommendation that competence assessments, particularly in relation to moving and handling, be reviewed.

There were clear recruitment procedures in place, which were generally followed to help protect the safety and wellbeing of people who used the service. However, we made a recommendation that the recording of recruitment procedures be reviewed to ensure a clear audit trail was in place.

The feedback received about the standard and variety of food provided was variable. Some people did not feel that current menus offered a nutritionally balanced diet and not all care staff were able to confirm that people were provided with choices about what they ate. We made a recommendation that the provision of meals and menu planning be reviewed to ensure people's individual needs and preferences are met.

There were processes in place to enable the manager to monitor safety and quality across the service. However, some of the areas we identified for improvement had not been previously identified through these processes. We made a recommendation that the area of quality and safety monitoring be reviewed to help ensure any areas for improvement are quickly identified.

We saw some very good examples of person centred activities being provided. The activities programme was being reviewed to look at how people who lived with dementia may be better supported in this area.

People we spoke with expressed satisfaction with the way their care was provided. People told us they felt safe and said they were treated with kindness and compassion.

People were satisfied with the support they received to access health care. People felt confident in the ability of care workers to meet their needs.

There were procedures in place to protect people who used the service from abuse or improper treatment. Care staff were aware of their responsibility to report any concerns about the safety or wellbeing of a person who used the service.

The manager cooperated with other professionals and made the appropriate notifications to the relevant agencies within the correct timescales.

People felt their choices were respected and that they could make decisions about their care and daily routines. The rights of people who needed support to make decisions about their care were respected because the manager worked in accordance with the Mental Capacity Act and associated legislation.

We found two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to safe care and treatment and dignity and respect. You can see what action we have told the provider to take at the end of the full version of this 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.

Safe moving and handling practices were not always followed in day-to-day practice.

Staff were aware of risks to people's health and wellbeing. Guidance in terms of how to support people in a safe manner could have been clearer in some cases.

Safeguarding procedures were in place and all staff were aware of them. The manager reported any safeguarding concerns in a prompt manner and cooperated with investigations.

People's medicines were in general, managed in a safe manner.

Staff were carefully recruited but information relating to individual recruitment processes could have been clearer.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Feedback about the standard and variety of food provided was variable and it was recommended this area be reviewed to see if improvements can be made.

There was a comprehensive training programme in place. However, it was recommended that processes for assessing staff competence be reviewed.

People were satisfied with the support they received to access health care and were confident in the ability of staff to meet their needs.

The rights of people unable to consent to all aspects of their care were protected because the service worked in accordance with the Mental Capacity Act 2005 and associated legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were aware of the importance of promoting people's privacy and dignity but were not always mindful of this in practice.

People spoke highly of staff and described them in ways such as 'kind' and 'patient'.

We observed some good examples of positive interaction between staff and people who used the service but also noted occasions when opportunities to engage with people in a meaningful way were missed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were in place and some contained very good examples of person centred care. However, other examples were found where clearer information was required to help ensure staff had a good level of guidance to meet people's needs.

People expressed satisfaction with the service provided and felt it met their needs.

The manager listened to people's views and took appropriate action to deal with any complaints made.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Most people we spoke with felt the manager was supportive and approachable and expressed confidence in the manager to address any concerns raised.

There were systems in place to enable the manager to monitor safety and quality across the service. However, we recommended these be reviewed to help ensure they captured all areas of potential improvement in a timely manner.

Headroomgate Nursing 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 review the rating for the service under the Care Act 2014.

The inspection took place on the 11 & 16 May 2016. The first day of the inspection was unannounced.

The inspection team consisted of two adult social care inspectors 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 care service. This expert had experience of caring for someone who lived with dementia.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

We spoke with eight people who used the service and two relatives during our inspection. We also had discussions with the manager, two nurses, three carers, the cook, a domestic assistant and the activities co-ordinator.

We spoke with four community professionals and contacted the local authority commissioning team. Their feedback is included throughout this report.

We closely examined the care records of five people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

During the inspection we conducted a SOFI (Short Observational Focused Inspection). A SOFI helps us to understand the experiences of people who are not able to talk in detail with us.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, five staff personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe receiving care at the service. Nobody had any concerns to share and all told us they were confident that staff knew how to keep them or their loved ones safe. People's comments included, "We're secure." "You're with a lot of people and the carers are nice." And, "It's easy going. I can sit in my own room."

We viewed a selection of people's care plans and saw these contained a range of risk assessments. These covered areas such as falling or developing pressure sores. Where risk was identified in relation to a person's health, safety or wellbeing, there was guidance for staff about how to support them in a safe manner. However, we found that some guidance could have been more detailed. For example, one person's care plan contained a risk assessment in relation to some high risk behaviours. The guidance in place stated, 'Use distraction techniques' but did not state what these techniques were.

We viewed the care plan of one person who had been known to grab carers when they were providing personal care by their hair, wrists or hands. There was no risk assessment in place regarding these behaviours or guidance for staff about how to maintain the person's and their own safety.

Moving and handling risk assessments were present in all the care plans we viewed along with individualised moving and handling care plans. These provided clear instructions about how to support people when transferring or mobilising. However, on two separate occasions we observed care workers transfer a person who used the service in a manner that was not in accordance with their moving and handling care plan or safe moving and handling techniques.

These omissions amounted to a breach of Regulation 12(1)(2)(a)&(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Everyone we spoke with felt the home was clean and comfortable. We saw there were a range of policies and procedures in place including infection control, fire safety and CoSHH (Control of Substances Hazardous to Health), designed to support staff in safe working practices.

A range of service certificates were available to demonstrate that equipment and facilities within the home were serviced on a regular basis, within appropriate timescales.

We saw that appropriate resources were usually available to enable staff to carry out their roles in a safe manner. However, we did note that on one occasion, earlier on in the year, staff had run out of some PPE (personal protective equipment). We discussed this with the manager who advised us new processes for ordering such equipment had been implemented to help ensure this did not happen again in the future.

PEEPs (personal emergency evacuation plans) were in place for each person who used the service. We found these varied in quality. Some provided a good level of personalised information about people's needs and the support they would require to evacuate the home in an emergency. However, other examples were

found to be of a more generic nature and lacked individualised guidance. It is recommended that all PEEPs be reviewed to ensure each person's PEEP contains individual guidance about their needs.

There were safeguarding procedures in place, providing guidance for staff about their responsibility to report any concerns that a person who used the service was at risk of being abused or had been the victim of abuse. The guidance included information about different types of abuse and advice in identifying concerns. Procedures were posted throughout the home and included contact details for the relevant authorities, to enable staff to escalate any concerns to the relevant agencies without delay.

Records demonstrated that all staff who worked at the service had been provided with safeguarding training, which was periodically updated. All the staff we spoke with demonstrated a good understanding of the area and their responsibilities to protect people in their care from harm. Staff also expressed confidence in the manager to deal with any safeguarding concerns in an effective manner.

Our records showed that the manager identified and reported any safeguarding concerns in a prompt manner. The manager cooperated with safeguarding investigations and provided information to the relevant professionals when requested. One community professional told us, "I find [name of manager] to be open and transparent and always willing to assist."

Everyone we spoke with told us they, or their loved ones, received their medication at the correct times. One person who used the service took responsibility for their own medication and we were able to confirm that the appropriate risk assessments had been carried out to ensure the person received any support they required to manage their medicines in a safe manner. They told us they were satisfied with the arrangements and commented, "I have a locked cabinet in my bedroom."

We viewed stocks of medicines within the home and found these to be securely stored. There was appropriate storage in place for items requiring refrigeration and controlled drugs.

We looked at the MARs (medicines administration records) for every person who used the service and found these to be generally satisfactory. Each person's MAR contained a photograph to reduce the risk of identification errors as well as details about any allergies they may have.

People's MARs usually contained the correct information in terms of medicines prescribed, doses and additional instructions, for example that the particular medicine should be taken before food. However, we noted that some records relating to topical applications, such as creams or ointments, stated 'Use as directed'. In some cases there were no further instructions about how and where on the body to apply the treatment.

Some people who used the service were prescribed medicines on an 'as required' basis. We found that in these circumstances there were usually clear instructions in place about when these medicines should be given. However, we found one example of a person prescribed a sleeping tablet who did not have this guidance in place. This meant the person was at risk of receiving the medicine when they did not need it or not receiving the medicine when they did need it.

One person who used the service sometimes received their medicines covertly, put into their food. We saw that the manager had followed due process in terms of ensuring that the person's capacity to consent had been assessed and that a best interest decision had been agreed with other relevant professionals and the person's family. However, there was a lack of information about how their medicines should be administered, for example, in what sort of food.

Records showed that regular audits were carried out of medicines and associated records by the manager. We were also able to determine that these audits were effective, in that issues were identified and addressed. However, some of the recent stocks received in the home had not been clearly recorded, which meant not all stock was auditable. This was pointed out to the manager who started to rectify the problem straight away.

We carried out a selection of checks of loose boxed medicines such as antibiotics. These were all found to be correct, indicating that people had received the correct dose at the correct times.

People we spoke with told us they felt there were enough staff. One person who used the service commented, "They do work well and they get the jobs done."

We asked people if they received assistance promptly when they requested it. People's responses included, "I don't use the bell. I wait until they come round." "They're quite good really [when answering calls for help]." Other people told us they didn't have to wait long.

There were set establishment staffing hours, which had been determined in line with the needs of people who used the service. We saw that the manager kept the levels under constant review to ensure any changes in people's needs were taken into account. We viewed a selection of rotas, which demonstrated that the service was consistently staffed to the set hours.

We viewed a selection of staff personnel files. We found in general, robust recruitment procedures were followed to help ensure new staff recruited had the necessary skills and knowledge and were of suitable character.

On all the files we viewed, evidence was available to demonstrate that candidates had been required to undergo a formal application process, including an interview to assess their suitability for the role they were applying for. A range of background checks were carried out which included the obtaining of references and a DBS (Disclosure and Barring Service) check, which would show if a candidate had any criminal convictions or had ever been barred from working with vulnerable people.

We noted that some people's application forms showed gaps in their employment history. We discussed this with the manager who advised us that any such gaps were always discussed at interview but this process was not recorded. It is recommended that a record be retained of such discussions for the manager's reference and as evidence that the gaps in employment history have been investigated.

Whilst references were in place on all the personnel files viewed we found that in some cases, information about the capacity in which people were providing references was not always clear. For example, whether the references were in relation to previous employment or character references. It is recommended that this information be more clearly recorded.

Requires Improvement

Is the service effective?

Our findings

We spoke with people who used the service about the health care support they received. People told us they were satisfied with this aspect of their care and expressed confidence in the staff team. People confirmed they were able to access external health care professionals when they required. One person told us, "I've just been to the doctors in a taxi with a carer."

People also felt that care workers would be aware and take appropriate action if they were unwell. Their comments included, "I think they would [be aware], or I could always ring the bell." "They've asked me a few times if I'm alright."

People's care plans demonstrated that the service worked closely with a range of community professionals including GPs, mental health professionals and community dieticians. We received positive feedback from one community health professional who commented, "I find [name of manager] and the staff very helpful. They are always able to give me the necessary information and take advice on board."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that care workers always asked for their consent before carrying out any care interventions. We also noted that in all the care plans we viewed, there was signed consent from the person, or someone with legal authority, to various aspects of their care.

Where it had been determined that a person lacked capacity to consent to any aspect of their care, the manager had followed due process and submitted DoLS applications.

Records were made of decisions made in people's best interests and these demonstrated that the manager had ensured all those involved in the person's care such as relatives, community professionals and advocates had been involved in best interest decisions.

Records showed that all staff had received training on the MCA and associated legislation. The manager demonstrated a good understanding of the legislation and how it should be applied to daily working

practices. However, in discussion we found that some staff members' understanding of the area was variable, although all were able to recognise what might constitute deprivation of a person's liberty and how to escalate any concerns.

People we spoke with expressed confidence in the ability of staff and felt they were suitably skilled to provide safe and effective care. One person commented, "I find them all very good. I think they must get good training – they all seem to know what they are doing."

We saw there was an established training programme in place, which included an induction provided for people at the start of their employment. We saw this was in line with the nationally recognised care certificate and included a variety of areas pertinent to the care worker's role.

There was an ongoing training programme, which included important health and safety areas such as moving and handling, as well as courses related to the needs of people who used the service, for example caring for people who lived with dementia.

The manager had a training matrix in place, which enabled her to monitor the area and identify when people were due to receive refresher training. Records showed such training was regularly provided. However, we observed two staff members who were both confirmed as having received moving and handling training carry out a maneuver which should not have been used on two separate occasions. This was discussed with the manager and it was recommended that competence assessments following training be reviewed to help the manager ensure people were suitably competent.

We saw that there were arrangements in place to provide staff with regular supervision and annual appraisals. This enabled them to meet with a manager on a regular basis to discuss areas such as personal development, work performance and any concerns either party may have.

People we spoke with told us they did not feel there was an excessive use of agency staff at the service. We saw from rotas that in recent months the use of agency nurses had increased due to a high staff turnover. However, this has been recognised by the manager who had taken steps, including recruitment of permanent staff, to address the situation.

Nutritional risk assessments were seen in each of the care plans we viewed. These were designed to identify those people who were at risk of poor nutrition and included measures to support those assessed as being so. Such measures included regular weight monitoring and where appropriate, referral to community professionals such as dieticians.

We viewed the care plan of one person, which showed they had been well supported in this area. They had been assessed on admission as being at high risk of malnutrition due to being underweight and having a low appetite. We tracked their care and saw they had benefited from a fortified diet and the use of nutritional supplements. Their intake and weight had been closely monitored and in the time they had been resident at the service, they had gained a significant amount of weight.

However, we received some concerns from a community professional regarding the nutritional support of another person. They advised us that staff at the home had failed to weigh one person for several months despite identifying concerns about their nutritional intake. When we looked at this person's care plan, we could see that staff had identified that the person had appeared to lose weight, but had been unable to weigh them due to their refusal. However staff had raised concerns with other professionals and were attempting to arrange the necessary support for them.

There were mixed comments from people who used the service about the standard of food provided. People's comments included, "It's alright." "The dinners are quite nice." "Average." "It's good, they always put the menu up." "It's indifferent. We get some of our own food in."

Two family members we spoke with felt the menus could be improved. One commented, "I've noticed people don't get what is on the board [menu board]. There is a lot of what I would call processed food like chicken nuggets and pizzas. I don't think that is what [name removed] would choose. Another said, "It's all frozen stuff like fish fingers."

We requested menus to look at the variety of meals provided. The cook advised us that menus were decided on a weekly basis by the cook and the manager who both went shopping for the food weekly. Menus were not planned in advance but depended on what was bought. The cook provided us with menus for January and May but was not able to produce any for the dates in between.

Although the menus viewed were varied, we noted that on some weeks, there was little evidence of fresh vegetables or home cooked meals. We spoke with the manager who advised that menus were developed in accordance with people's preference and attempts were made to provide a good deal of variety. However, it is recommended that processes for developing menus be reviewed to help enable the manager to ensure that people are provided with nutritionally balanced meals.

One the inspectors joined residents for lunch and noted the food was served 20 minutes late. The steak pie, which was served, was very dry and the pastry was so hard, it was difficult to cut. It appeared that everyone had the same meal. However, two people were given sweetcorn because they didn't like the vegetables being served. The couple who bought some of their own food, told us the staff heated it or cooked it for them. We were also aware that one person was regularly provided with their favourite meal, a curry, and another who had wished to have takeaway pizza on one occasion, had been supported to do so.

We asked one staff member how she would ensure that people who used the service were given a choice at mealtimes. She replied, "Food's nothing to do with me. We're told by the chef what's for tea and we just serve it." This approach did not support people's opportunities to make choices about what they had to eat. It is recommended that the manager review the area of meal time provision, in relation to both the standard of food served and the processes for offering people everyday choices about what they have to eat.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with who used the service told us they felt their privacy and dignity was respected. One person described how care workers maintained their privacy and dignity when assisting him to have a bath. However, a family member we talked with expressed concern that they often found their loved one wearing other people's clothes or other people wearing their loved one's clothes. They commented, "[name removed] is always wearing someone else clothes, this is an ongoing situation." They went on to tell us that their loved one had always been supported to have a nice hair style and manicure but recently this has not always been the case. This did not promote the person's dignity or opportunity to express their individuality.

We asked staff to describe how they would promote the privacy and dignity of the people they cared for. Staff were able to give us examples of good working practices, such as ensuring doors were closed when providing personal care and knocking on people's doors, before entering. Staff also spoke of the importance of speaking with people in a discrete manner about their care. However, we observed one care worker approach a person who used the service in the lounge and say, "Shall we check your pad?" loudly enough for other people in the room to hear.

These findings demonstrated a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We received positive feedback about the approach of staff and how people felt about the way their care was provided. People's comments included, "They're very kind. They help you out." "They're very good. Patient and always there to help us." "I get on with all the staff, they're kind." "I like the banter with the staff."

Throughout the inspection we observed care workers interacting with people and providing care and support. Some of these observations were of a positive nature and on some occasions, we saw care workers promptly responding to people's requests for assistance in a kind and positive way. For example, one person was heard to say that he fancied a hot chocolate and some biscuits, and these were provided straight away.

However, we also noted some opportunities for positive interaction were missed. Care workers were seen to be present in the communal lounge area for all of the day. For much of this time, we noted that care workers sat with people but didn't interact with them. One person who used the service spoke repeatedly about a baby dying. At times she appeared to be distressed. However, care workers ignored her for most of the time and made no attempts to comfort her, although we saw the activities co-ordinator make some attempts to engage with her. We spoke with staff about this person and were told she spoke about the baby dying most of the time. However, when we checked her care plan we found there was no reference to this, or how to provide support and reassurance.

Two members of staff sat in the lounge on either side of a person who used the service to have their lunch. They did not speak with the resident between them, who was fully awake and watching TV. We also noted

that staff did not interact with people over lunch, other than to provide them with the necessary assistance.

We asked people who used the service if they found care workers had time to sit and chat with them. One person commented, "Not really," while another said, "Sometimes." Another person's response was, "They are very attentive, but I wouldn't say they sit down." However, everyone we spoke with told us they felt staff always listened to them and responded to their requests for assistance.

Care plans viewed contained information about people's personal wishes and preferred daily routines. People we spoke with told us they could make their own choices about daily routines such as about getting up or going to bed. Their comments included, "They very rarely wake me up. I wake up at 06.30 and come for breakfast at 7." "I can more or less decide myself." "I pretty much do what I want." "If I want any help, they are there for me."

An advocate is an independent person who can assist people who use services in expressing their decisions and choices. Information was available for people about how to access local advocacy services. One person who used the service was able to tell us about the local advocacy services and the sort of support they offered. We also noted when viewing the care plan of another person, that the manager had arranged for an independent advocate to support them to express decisions about an important aspect of their care.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they felt the service was a good one that met their needs. In general, people expressed satisfaction with the service provided and when we asked people what they felt the service did well, their responses included, "I've got my own room." "We can do what we want, you can get involved if you want." "The way they look after you and the meals." "We can go out whenever we want." A relative commented, "I think standards here have improved greatly over the last year or so but I do think there are more improvements to be made."

People we spoke with told us they felt care workers understood their, or their loved one's needs. We saw the manager arranged for a pre-admission assessment to be carried out prior to any new person being admitted to the service. This meant they could ensure that the person's needs could be met and that staff had some understanding of the support they would require.

Plans of care were in place for each person who used the service. These documents provided a picture of the person's day-to-day needs, the support they required and covered a wide range of areas.

We viewed some good examples of person centred care planning. For example, the care plan of one person who lived with dementia included a good level of detail about their individual methods of communication and stated, 'Staff should take time to get to know me and use simple sentences when communicating with me, which helps me understand the support and care I am being given.' Another person's plan in relation to dressing stated, 'I like to wear purple clothes and I like to wear jewellery.' This level of detail assisted staff in providing support to people that met their personal needs and wishes.

However, we also came across some examples where more detail about how the person should be supported in a particular area would have been helpful. For example, the care plan of one person who had some complex behavioural needs stated, 'Use distraction techniques.' But did not describe what these techniques were. We also saw another person's mobility plan which stated, 'I am able to transfer with the assistance of one or two carers.' Clearer guidance was required to describe when one or two care workers might be required and what the assistance was that the person needed.

Most people's care plan contained a social history. This gave the reader some insight into the person, the people who were important to them, previous interests and hobbies and significant life events. However, this information was not present in all the plans we viewed.

People we spoke with were aware of their or their loved one's care plans and the information they contained. One person who used the service told us, "I signed it. I read the main bits. If I wasn't sure about anything, I asked."

We spoke with people who used the service and their relatives about the activities provided at the home. People's comments included, "I've got a computer upstairs, I play dominoes and cards, and I join in board games and quizzes." "Occasionally they get someone in music wise." "I would like to get out more". "I build

models, watch TV I have a computer. I don't get bored."

We asked people if activities could be improved and responses included, "Nobody ever takes me out." And, "I'd like to go out for more walks."

There was an activity planner displayed in the dining room which listed a variety of activities including board games, quizzes, dominoes, gardening and shopping trips.
There was an activities coordinator employed at the service. Several people we talked with spoke very highly of this staff member who escorted two people out for a trip on the day of the inspection.

We spoke with the activities coordinator who shared some positive examples of activities that had taken place and further plans for the future. We heard about one person who had expressed a desire to return to a hotel where he had worked for many years. This was organised with the hotel who invited him and two friends for a nice lunch and tour. We also heard that a small group of people who used the service and spent time together socially, were planning to go on a short caravan break with the activities coordinator.

Although we heard some good examples of activities taking place, we observed some people who used the service to be sitting quietly for much of the day with little engagement and very little activity. We spoke with the activities coordinator who explained they were looking to develop the activities programme for people living with more advanced dementia, further. This would be of benefit to those people who may not take part in the group activities provided at the service.

Evidence was available to demonstrate that the manager carried out periodic satisfaction surveys to enable people who used the service and other stakeholders to express their views and make comments and suggestions.

The most recent survey had been carried out in April 2016 and we saw that the results of this were posted in the entrance of the home for people's information.

We also viewed minutes of residents' meetings that took place on a quarterly basis. Within the meetings, people were updated about any issues affecting the service and invited to express their views about the running of the home.

We were able to confirm the manager took account of people's views and took action to respond to them. For example, we saw the area of activities had been raised as an area for development during recent residents' meetings. In response to this, the area had been reviewed, a new activities coordinator had been employed and changes were being made to the activities programme.

Most people told us they felt comfortable to raise any concerns. One person we spoke with had raised a complaint, which they felt had been addressed in a satisfactory manner.

There was a complaints procedure in place, which provided information for people about how to raise concerns and included contact details of other agencies they may wish to contact, such as the Care Quality Commission and Local Authority.

A record of any complaints made, the outcome of investigation and action taken as a result, was available for inspection. This demonstrated that concerns were taken seriously and that action was taken to ensure people received a satisfactory outcome.

Requires Improvement

Is the service well-led?

Our findings

There had been some changes to the management of the service prior to the inspection, which meant that the manager was no longer registered with the Care Quality Commission. This meant the service was without a registered manager. We were advised that the provider was currently in the process of finding a suitable manager who would, following their appointment, be put forward for registration with the commission. In the interim period, the previously registered manager was continuing to oversee the day-to-day running of the home.

We were informed shortly after the inspection that the service had made a significant change to their statement of purpose in that they had removed their intention to provide services for people with mental health nursing needs. This had led to one person, who had used the service for several years being given notice. This was discussed with the manager and local safeguarding team. Concerns were expressed that this situation could have been managed in a more positive manner.

The majority of people who used the service or their relatives felt the home was well managed. However, we spoke with one set of relatives who felt their opinions had not always been fully taken into account and that there were occasions when the manager had not responded positively to their views.

Community professionals who we made contact with were positive about the management of the service describing it in ways such as, 'well managed', 'professional' and 'responsive.'

Staff spoken with during the inspection told us they were satisfied with the level of support they received. One care worker described the manager as 'very approachable' and another commented, 'I've never felt that I could not go to her [the manager].'

However, we were contacted by two former staff members who expressed their concerns about the management of the home stating that they did not feel the culture of the home was a positive one. They expressed a view that they had not been fully supported by the manager during their employment. We discussed this with the manager who felt the former staff members were aggrieved at being the subject of disciplinary proceedings. It was not possible to ascertain the facts in this situation. However, the manager was asked to consider the comments and explore whether the views shared were indicative of the views of any staff currently employed.

People were in general, aware of the management structure and who to speak to if they had any concerns. Staff were aware of the service's whistleblowing policy and the current staff who we spoke with during the inspection, expressed confidence in the manager to deal with any concerns properly. One staff member commented, "If you have any worries or concerns you go to the manager or home owner, or pass it on yourself if it's not dealt with properly." And another said, "I think the manager tries to do everything she can. She listens. If there's any concerns she tries to fix it during the day."

There were a range of processes in place to enable the manager to monitor safety and quality across the

service. These included a range of audits in areas such as care planning, medicines management and training. Adverse incidents such as complaints, accidents and safeguarding concerns were monitored and analysed to ensure any potential learning was obtained and cascaded throughout the team. Pressure sores, hospital admissions and falls were also closely monitored and analysed, to enable the manager to assess the outcomes experienced by people who used the service.

Whilst we saw these quality assurance systems were in place and were able to identify examples of where they had been effective, we did identify two breaches of the health and social care act during this inspection, relating to safety and dignity. The breaches would indicate that the processes used to ensure quality and safety across the service were not fully effective. It is therefore recommended that these be reviewed to ensure they promptly identify areas for improvements.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had failed to ensure that adequate arrangements were in place to ensure people were cared for in a manner that promoted their privacy and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure that adequate arrangements were in place to assess and manage risks associated with people's care.