Osmaston Grange Care Home Limited

Osmaston Grange

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

This inspection was unannounced and took place on the 9 and 16 February 2016.

Osmaston Grange Care Home provides accommodation for up to 80 older people who require nursing or personal care, including some people who are living with dementia. The care home comprises of two buildings. An older type building accommodates older people who require personal care only. A newer type split level building over two floors, accommodates older people who require nursing care. This includes some people living with dementia, who are mostly accommodated on the lower floor of the unit.

There is a registered manager at this 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 our last inspection in December 2014 and January 2015, people were not fully protected from risks associated with unsafe medicines practice or insufficient staffing. This was because people's medicines were not always being safely managed and there were not always sufficient staff to meet people's needs. These were respective breaches of Regulations 12 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection, the provider told us what action they were going to take to rectify the breaches and at this inspection we found that improvements were made. Further improvements were in progress to help to ensure that people were consistently supported in a prompt and timely manner when they needed assistance.

At this inspection, there were 66 people accommodated at the service. This included 31 people receiving personal care who were accommodated in the older type building. In the newer build unit there were 19 people receiving nursing care and 16 people living with dementia who received personal care only.

The provider's arrangements for the prevention and control of infection and the cleanliness and hygiene of the premises, did not fully protect people from the risks of cross contamination. This was because not all areas of the home were being kept clean and hygienic. Staff, were not provided with all of the information they needed and recognised guidance was not being followed for the prevention and control of infection at the service.

Risks to people's safety were mostly taken into account in the planning and delivery of their care and people's medicines needs were safely managed.

Staff did not always support people in a prompt or timely manner when they needed assistance. Action was being taken to help improve this through staff development and recruitment and other management arrangements.

Staff recruitment arrangements helped to ensure that staff, were suitable to work at the service and provide people's care.

Emergency planning arrangements mostly helped to promote people's safety in the event of illness or injury. The manager agreed to take action to address two areas of their policy guidance that did not fully inform staff, to show related emergency procedures.

Staff followed the Mental Capacity Act 2005 MCA to obtain consent or appropriate authorisation for people's care. However, processes were not always checked for recorded decisions made by external medical professionals about people's care and treatment at the service to make sure these were valid. The manager agreed to take action to address this.

Overall, staff understood people's health and nutritional needs and supported them to maintain and improve this. People's associated care plans records mostly but not always provided staff with accurate information about this for them to follow.

People were supported to access external health professionals when they needed to and staff usually followed their instructions for people's care. Action was taken to improve communications where delays had occurred to help ensure that care instructions from external health professionals were followed in a timely way.

People received adequate nutrition, which usually matched their dietary requirements and recorded preferences. People's dietary needs were assessed and regularly reviewed but not always accurately recorded.

Staff understood risks to people from malnutrition and the actions they needed to take to mitigate this and catering staff mostly understood people's dietary requirements. We recommended additional education is provided for staff in relation to nutritional risk assessment and food fortification.

Overall, staff received the training and support they needed to provide people's care. Revised supervision and induction arrangements were determined to address identified gaps.

People had good relationships with staff that were kind and caring. Staff treated people with respect and promoted their rights and choices in care. People and their relatives were informed and involved in the care provided and made welcome in the home.

Staff, were generally helpful and often, but not always observant of people's needs or prompt to provide people with general personal assistance when they needed it. Staff acted promptly to seek advice when people's medical or health needs changed.

Staff understood people's communication needs and often but not always encouraged and supported people to be as independent as they could be.

People's care was often personalised and staff mostly understood people's preferred personal care and daily living routines. People were often but not always supported to follow their interests and engage in their preferred social and recreational activities and staff were often not always fully informed to support this.

People were confident to raise any concerns about their care, but not accurately informed to make a formal

complaint if they needed to. Records showed some changes were made from complaints to help improve communication and personal care systems.

The provider's arrangements to respond to important events at the service and to check the quality and safety of people's care were not effective. This was because as they were not always proactive or consistent to determine any service improvements that may be needed.

The provider's arrangements to obtain formal and confidential feedback from people, relatives and visiting professionals were not being followed to help inform and improve the quality of care provision at the service.

People, relatives and staff felt the new manager was approachable and listened to their views and suggestions about people's care.

Staff mostly understood their roles and responsibilities for people's care. Recent management instructions about expected care standards and some improvements needed helped to make sure that staff fully understood this.

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

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 always safe.

Arrangements for the prevention and control of infection and cleanliness and hygiene did not fully protect people from unsafe care.

Staffing and emergency arrangements were mostly sufficient and safe, but people did not always receive prompt or timely assistance when they needed it.

People felt safe in the home and their medicines were safely managed. The provider's recruitment procedures helped to protect people from the risk of harm and abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff usually followed the Mental Capacity Act 2005 (MCA), to obtain people's consent or appropriate authorisation for people's care. The provider had not always checked to make sure that decisions recorded by external medical professionals for people's care and treatment could be legally followed.

Staff mostly understood and supported people's health and nutritional needs. However, these were not always accurately recorded or fully understood in relation to people's dietary requirements.

Staff usually received the training and support they needed to provide people's care. Revised communication, supervision and induction arrangements were determined but not fully implemented to help promote consistent and timely care.

Is the service caring?

Good

The service was caring.

People were satisfied with their care and they had good relationships with staff that were kind and caring and treated them with respect. People's relatives were made welcome and

kept appropriately informed and involved in people's care.

Staff promoted people's dignity and rights and they consulted with people and supported their care and daily living choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff, were generally helpful and often but not always observant or prompt to provide people with the assistance and support they needed. Staff acted promptly when required following changes in people's health needs.

People's independence and their preferred daily living routines and lifestyle preferences and choices were often, but not always promoted in a way that met their needs.

People and their relatives were mostly confident to raise concerns about their care but not accurately informed to make a formal complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Arrangements to respond to important events at the service; to check the quality and safety of people's care and to mitigate any risks to people from this, was not always effective.

Formal and confidential feedback was not consistently obtained from people to help inform and improve the quality of care provision at the service.

Staff were mostly understood their roles and responsibilities. Recent management instructions helped to make sure they fully understood this.

Osmaston Grange

Detailed findings

Background to this inspection

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

We visited the home on 9 and 16 February 2016. Our visit was unannounced and the inspection team consisted of three inspectors and a specialist advisor in nutrition and dietetic health.

Before this inspection we looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law. For example, a notification of a management changes. We also spoke with local health and social care commissioners about the service. At the time of our inspection there was an ongoing investigation into the circumstances surrounding the death of a person that used the service.

During our inspection we spoke with 16 people who lived at the home and three people's relatives. We spoke with two nurses, three senior and eight care staff, one domestic, a cook and two catering support staff. We also spoke with the manager, the provider's nominated representative and three external health professionals who regularly visit people at the service. We observed how staff provided people's care and support in communal areas and we looked at 38 people's care records. This specifically included 28 people's nutritional care plans and related records. We also looked at some other records relating to how the home was managed. For example, medicines records, staff training records and checks of quality and safety.

As some people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2014 and January 2015, people were not fully protected from risks associated with unsafe medicines practice or insufficient staffing. This was because people's medicines were not always being safely managed and there were not always sufficient staff to meet people's needs safely. These were breaches of Regulations 12(2) (g) and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection, the provider told us what action they were going to take to rectify the breaches. At this inspection we found that improvements had been made. However, further improvements were still in progress to help to ensure that people consistently received timely assistance from staff when needed.

All of the people we spoke with and their relatives said they received the care they needed and felt safe at the service. However, they felt that people had sometimes waited too long for assistance when they needed it. For example, when people needed assistance to go to the toilet. Most people and a relative said this had recently improved, but all felt that further improvements were needed. All said that delays sometimes occurred with meals and drinks.

Staff felt that staffing was mostly sufficiently planned for them to provide people's care. During our inspection we observed that people accommodated in the residential unit were often but not always provided with prompt assistance when they needed it. For example, some people waited for over half an hour for their lunchtime meal to be served to them at the table. In the nursing unit we observed that people received the support they needed at lunchtime to eat and drink in a timely way. An additional staff member had recently been appointed to a dedicated role there, to help ensure people's timely support with meals and drinks. Rotas showed that this support was provided at breakfast and lunchtime on the nursing unit, but not at weekday tea time or weekend meals. Additional support was not provided in this way at mealtimes on the other care units.

We discussed our findings with management, who told us about the action they were taking to address this. This included the further appointment of dedicated care staff to help ensure people's timely support with their meals. Recent records showed that staff absences and people's care needs were being monitored. This helped to inform staff rota planning and deployment arrangements in the interim.

We found that people's medicines were safely managed. At our first inspection visit we found there was an explained delay for a few people's medicines. However, we saw that the nurse noted the times of people's medicines that were delayed. They explained that this helped to ensure the correct time intervals before giving people their next prescribed dose, which we later observed was followed safely. They also told us that any instructions for people's medicines to be given at specified times had been strictly followed. People's medicines records also showed this. For example, medicines that were prescribed to be given to one person before their breakfast meal. This helped to mitigate the risk of people from unsafe medicines administration.

We observed nurses giving people their medicines safely and in a way that met with recognised practice.

Two nurses that we spoke with told us they had received medicines training, which included an assessment of their individual competency. Information was provided to support staff responsible for people's medicines, which referenced nationally recognised guidance. People's care plans also provided staff with relevant information about people's own medicines. For example, known side effects and action to take if these were observed. This helped to make sure that people's medicines were safely managed.

The provider's arrangements for the prevention and control of infections, including the cleanliness and hygiene of the premises, did not fully protect people from the risk of unsafe care.

Some people we spoke with felt that parts of the home were not kept as clean as they should be. We also observed that not all parts of the home, including some of the equipment and furnishings used for people's care were not always clean or hygienic. For example, the medicines room in the nursing unit had unwiped spillages on storage facilities and old dust and debris on shelving and around floor edgings, which were a potential harbour for germs. Some equipment, such as hoists and toilet grab rails were not clean with rusting or flaking coatings. Some comfortable seating in communal areas was either stained or damaged and sluice areas used for cleaning and storing equipment, such as commode pots, did not always provide smooth sealed surfaces. Walls and tiling in some communal areas were damaged and exposed porous surfaces. These surfaces were also a potential harbour for germs as they could not be effectively cleaned. This increased the risk of infection to people through cross contamination and this risk had not been assessed.

Staff, were not provided with all of the recognised guidance they needed to follow to maintain cleanliness and hygiene and for the prevention and control of infection at the service. Cleaning schedules did not provide staff with the information they needed. This included information about the areas and equipment to be cleaned, how often and the products to use. Management were not aware of recognised national guidance concerned with the prevention and control of infection and cleanliness in health and adult social care services, known as 'The Code of Practice.' The Code helps registered providers to understand what they need to do to comply with the requirement for cleanliness and infection control.

We discussed our findings with management who agreed that improvements were needed. They showed us a recorded audit report of infection control and cleanliness at the service. This was undertaken by the local health care commissioner's infection control team in February 2016 following concerns raised with them. The report also showed that standards of cleanliness and hygiene were not always ensured or maintained at the service and detailed areas, where improvements were needed. The manager told us about some of the immediate improvements they had made from this report. The manager also advised they were in the process of devising an action plan to address all of the improvements from the report findings.

We found that the premises and equipment were not always clean and hygienic and the provider's arrangements for the prevention and control of infection did not fully protect people from the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All of the people we spoke with said they were confident and knew how to raise any concerns about people's safety if they needed to. Information was displayed for people and visitors about what to do if they suspected or witnessed the abuse of any person living at the service. Staff we spoke also understood the procedures to follow if this occurred. Staff described satisfactory arrangements for their recruitment and employment to check they were suitable to work with people accommodated at the service. This helped to protect people from harm and abuse.

Risks to people from their health conditions were assessed before people received care and regularly reviewed. People and their relatives felt that staff generally understood and supported their safety needs. For example, staff supported people to move or take their medicines safely. We observed that people were provided with the equipment they needed, such as walking frames to support their safe mobility or special bed mattresses and seat cushions to help prevent skin sores. Equipment used for people's care was checked and serviced for safe use. This showed that people's safety needs were considered and promoted.

Procedures were in place for staff to follow in the event of any foreseeable emergency in the home. For example, in the event of a fire alarm, accident or injury. However, there were no emergency procedures and staff gave conflicting views, if they needed to access the spare set of medicines keys or should any person experience an unlikely adverse reaction to their medicines. We spoke with the manager about this and they agreed to take action to address this to ensure people's safety should this occur.

Appointed care staff, were trained as first aiders and regularly deployed to provide initial emergency support to people and staff in the home, in the event of any health emergency. However, at our first inspection visit we found that the provider's first aid boxes were not regularly checked and almost empty. They did not provide staff with the equipment they may need in the event of a health emergency or as outlined in the provider's written first aid policy. We spoke with management about this and they took immediate action to address this.

The most recent report from the local fire authority from their follow up visit to the service in September 2014 showed that satisfactory arrangements had been achieved for fire safety following their fire safety enforcement notice of June 2015.

Requires Improvement

Is the service effective?

Our findings

Staff followed the Mental Capacity Act 2005 (MCA) to obtain consent or appropriate authorisation for people's care. The 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 so that they can 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 Safeguarding (DoLS).

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

Five people's care records we looked at showed that advanced decisions had been made in their best interests relating to their treatment in the event of their sudden collapse. However, two records did not show a valid reason for the decisions made. This included one record, which showed that relevant parties had not all been consulted to inform the decision. Three records were not signed by the health professional responsible for completing them. An external medical professional concerned with people's care and treatment was responsible for their completion. However, the provider had not recognised their responsibilities to check that the MCA processes were followed to support the decisions. We discussed this with management who agreed to take the action necessary to address this.

One person's records showed they had made an important decision about their care and treatment in the event of their sudden collapse, which staff knew. Some people had designated others to make important decisions on their behalf about their care, finances or both by way of legally appointed attorney powers. People's care plans identified where such arrangements were made. This helped to ensure that appropriate decisions would be followed in relation to people's care, treatment or finances in their best interests.

People were supported to make choices and they were asked for their consent whenever they were able. We saw that staff asked people for their consent to care or support throughout our inspection. Records relating to people's consent were signed and dated and their purpose was clear. For example where people had been asked for and given their consent to receive health vaccinations.

Some people were not always able to consent to their care because of their health conditions. Overall staff understood people's care to be provided in their best interests. People's care records showed an appropriate assessment of their mental capacity and a record of decisions about their care and support, made in their best interests.

Staff told us about a number of people whose freedom they were restricting in a way that was necessary to

keep them safe under a DoLS. Records showed that for each person, this was either formally authorised by the relevant local authority or appropriate steps had been taken to obtain an authorisation. This is required when a person's freedom is being restricted in this way. This showed that the service sought people's consent or appropriate authorisation for their care.

Overall, people were supported to maintain and improve their health and nutrition. Staff we spoke with understood people's health conditions, how they affected them and the care interventions they needed to follow to support people to maintain or improve their health.

People's care plans were often well recorded and regularly reviewed. Two people's care plans relating to their dementia needs showed they could sometimes easily became anxious or distressed. Their care was planned to use the least restrictive care or treatment measure and instructed staff to, 'Use reassurance and distraction techniques.' However, the care plans did not specify the individual care interventions that staff needed to follow to support the person when this occurred, which could result in inconsistent care. We discussed this with staff and found they understood people's care needs and their individual care requirements. We also observed that staff supported one person in a way that was meaningful to them when they became anxious and distressed. This was consistent with the care approach which staff had described.

We discussed our findings with the manager and they told us they would take action to address this. They also showed us records of recent checks of people's care plans and related health records in the residential unit. The results from this showed that record keeping improvements were needed. Minutes of a subsequent meeting held with staff specified the actions to be taken take action to ensure the care plans were effectively recorded. The manager explained that further checks of this were planned across the service. This helped to mitigate the risk of people receiving inappropriate or ineffective care.

People were supported to access external health professionals for the purposes of routine and specialist health screening. For examples, for foot care or diabetic health screening. People's care plans showed that instructions from external health professionals were being followed. Visiting district nurses told us there had sometimes been delays in staff following their instructions for people's care. The manager told us about the action they had action taken to improve and review communications about changes in people's health needs and related care requirements. This included the introduction of a revised care handover record for staff to follow, together with weekly review meetings with a lead district nurse. This helped to ensure that people received the care they needed in a timely way.

People said they were usually provided with the support they needed to eat and drink and that a choice was provided. However, we received mixed views from people about the quality and timeliness of their meals and drinks. Many said they enjoyed their and some said they did not. For example, one person said, "The food is marvellous; good and hot; I'm never hungry." Another person said, "No imagination; tasteless food." People, who did not enjoy their food, often described it as 'over blended.' For example, one person said they only needed their meat to be blended because they had difficulty chewing this, but said that their entire meal was always blended.

Overall, we found that people received adequate nutrition. Staff offered people a choice of meals and drinks and gave people the assistance they needed to eat and drink. Some people chose to eat their lunch in their own rooms and many people choose to eat in the main dining rooms on each unit.

There were notable differences in relation to table setting and atmosphere across the three units. On the nursing unit lunchtime was a cheerful, sociable and relaxed atmosphere where tables were set beforehand

with cloths, cutlery and condiments. Staff chatted with people and took time to ensure they were happy with their meal. On the other two care units, tables were not set before-hand, which left people sitting and waiting for this. On one of those units, meals were served at different times to people living with dementia, who were sitting together at tables. This showed that full effort was not made by staff to promote a social mealtime experience.

Daily menus showed a choice of hot and cold food at each mealtime and showed a reasonably varied and balanced diet. We saw that people were provided with foods of their choice, which usually matched their dietary plan and recorded preferences, although the reason for some people's pureed meals was not always accounted in this way.

Some people had difficulty swallowing because of their health condition. We saw they were provided with the correct consistency of food and drinks, which met with their dietary requirements and related advice relevant external health professionals. Catering staff were provided with information about people's dietary requirements and demonstrated an adequate understanding of this. For example, some people needed their food fortifying to support their energy and weight requirements. The cook was able to describe some effective ways of achieving this. However, there were no standardised recipes for food fortification for the cook to follow to assist them.

People's records showed that two different nutritional assessments were used. These gave conflicting results about risks to people from malnutrition and subsequent instructions for care actions that may be required. We raised this with the manager and by our second inspection visit they had taken action to ensure that only one of the assessment tools, nationally recognised, was used. This assessment tool is known as the multi universal scoring tool or MUST.

We checked the nutritional assessments and care plans of most people accommodated on the nursing and dementia unit and found they were not always accurately recorded. However, where there were risks to people from malnutrition, people's related care records and discussions with staff showed that appropriate actions were taken to address this. For example, dietetic advice was sought and followed. We raised this with the manager and by our second inspection visit they had taken action to address this.

We recommended additional education is provided for staff in consultation with a relevant external health professional for the accurate completion of the MUST tool and food fortification.

Otherwise, training records showed that staff had the skills and knowledge to provide people's care. Staff confirmed they received the training they needed to perform their role and responsibilities. This included essential health and safety training and training relating to people's health conditions. Staff said they mostly received the supervision they needed from a senior staff member. Some staff said that the frequency of their individual supervision sessions had 'dropped off' during a period of recent management change. However, records showed that revised arrangements were timetabled with staff to ensure they received regular supervision and support.

Training records showed that essential health and safety training was provided for staff and that they were supported develop their skills and knowledge to provide people's care. Nursing staff were supported to undertake extended role training and training for their continued professional development. For example, training for urinary catheterisation and for the management of diabetes and wound care training. Care staff were supported to achieve national vocational qualifications relevant to their role. The Care Certificate was also introduced for new care staff to complete. This identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those

staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care. This showed that staff were trained and supported to perform their role and responsibilities.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and felt they had good relationships with them. We received many positive comments about this. One person said, "Staff are lovely, I'm pleased with the care I get." Another person told us, "Staff are very good and helpful. They also confirmed staff supported their personal care choices and preferences.

We saw staff, were kind and caring. For example, staff told us about one person living with dementia who often worried about the times and purpose of their medicines as they often forgot what they were for. We saw that staff took time to reassure the person when they became upset about this. Staff helped them to understand what their medicines were for and why they needed them and took care to do this in a way that was meaningful to the person. We saw that the person was reassured by staff's caring approach, because they helped the person to understand that they needed them for their physical health.

We saw that people were offered choices in their daily living routines, such as where to spend their time. Staff were able to describe how they offered choices to people, for example, in relation to meals and social activities. We saw that people were able to refuse options, which showed their choice was respected. For example, one person chose to stay in their own room to spend some quiet time there.

People's relatives said they felt welcome in the home and confirmed they were kept informed about their relatives care and any changes. People and their relatives were appropriately involved in people's care planning. People told us they were involved in discussions about their care. Where they had the capacity to do so, we saw that people had signed their agreement to their care plans. Care planning was inclusive and took account of people's known views and opinions. Staff understood people's choices and arrangements for their family involvement.

People told us that staff treated them with respect and supported their rights to dignity, privacy and choice. One person said, "Staff are respectful; they support my care wishes."

Throughout our inspection we observed that interactions between people, visitors and care staff were warm, caring and good natured. There were a lot of cheerful conversations and we saw that staff often sat with people and listened to them. We also saw that when staff supported people, they were respectful and patient in their approach. For example, supporting people to mobilise.

We found that promoting people's rights in their care was a part of the provider's staff induction and training programme and their stated aims of care. This included promoting anti-discriminatory practice and ensuring confidentiality in relation to protecting people's personal information. Staff understood this and mostly promoted people's rights when they provided care. At our first inspection visit we observed that confidential personal information relating to people's care was left out openly and unattended by staff in a communal area. However, the nurse in charge noted the same and took action to address this. They ensured that the information was safely stored and instructed staff about this.

Otherwise, staff understood the importance of ensuring people's rights, including their privacy and dignity and demonstrating a caring attitude. They gave us some examples of how this was done when the provided care. This included giving people time to make choices about their care and daily living arrangements and ensuring people's privacy, by knocking doors and making sure people were covered during personal care. This showed that people were treated with kindness and compassion and that staff promoted their rights to dignity, choice and respect.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives said that staff, were generally helpful but not always prompt to provide people with the assistance and support they needed. People and their relatives said this had improved over the previous month, but felt that further improvements were needed. Examples they gave us mostly related to the length of time people waited for assistance with their personal care needs and drinks.

One person said, "I'm happy living here but sometimes it takes too long for staff to come when I need help." Another person's relative said, "I'm happy with the care, but sometimes it takes far too long for staff to come when assistance is needed to use the toilet or to have a drink when they ask." People and their relatives confirmed that drinks were routinely offered at regular intervals, but said that people often had to wait too if they requested additional drinks when they were thirsty. They also pointed out that drinks were not readily accessible, for them or their relatives to obtain these independently.

Staff told us they tried to be responsive to people's needs. For example, one staff member said, "We know people's routines and try to encourage their independence to do what they can for themselves rather than doing it for them." During our inspection we observed many instances when this occurred. For example, when staff supported one person with their mobility, they made sure that their walking frame was to hand and discreetly observed to make sure they were to hand of the person needed assistance.

We observed that staff, were visible throughout our inspection and they often, but not always, acted promptly to support people when needed and responded to their requests. At lunchtime tables were not properly set when people were seated in two of the care units. Water and drinking cups were not readily available for people, or their relatives on their behalf, to help themselves if they wished to do so at any time of the day, which did not promote their independence.

At other times during our inspection we observed many instances when staff supported people's independence as much as possible. For example, we saw that staff encouraged and supported people to walk or to eat independently where possible. They ensured that relevant equipment was provided, to enable people to do this. For example, correct seating to assist people to stand independently or eating aids and utensils.

People were not consistently supported to follow their interests or take part in their preferred social and recreational activities of their choice. One person said, "There is not enough to keep us going; there's little in the way of activities, but a film sometimes." Another person told us they enjoyed participating in soft ball game exercises, but said, "It doesn't happen very often; they (staff) haven't got time." One person told us they were rarely supported to go out into the local community, which they liked to do." Another person said, "On the whole it's not too bad, but I wish we went out more."

Other people said they were satisfied with the arrangements for their social support and engagement and told us that staff supported them as much as possible to do this. Two people told us they enjoyed reading the regular supply of books and magazines made available to them and that staff supported them to do

crosswords and puzzles. Many people said they were encouraged to have their own rooms decorated to their taste and had personalised their rooms with their own personal items. Some people told us about arrangements for them to engage in spiritual worship, which met with their religion.

We saw some people were individually engaged in personal activities, such as watching TV, listening to music, reading or engaging in conversation with peers or visitors to the home. We saw that some people were supported to participate in reminiscence and music therapy, which they enjoyed.

Staff told us they tried to be responsive to people's needs. One staff member told us, "We know people's personal routines." We saw that people's care records contained relevant information about their health and personal care routines preferences and routines, but information about people's life history was not always recorded to inform and support their social care needs and related personal interests. The activities co-ordinator told us they were working with people to provide a 'This is Me' booklet to help to address this.

We observed staff supporting one person who was not able to communicate verbally because of their health condition. Staff showed that they understood the person's needs and wishes relating to their daily living choices and they knew how to communicate with the person to ascertain their views about this.

People and their relatives were mostly confident to raise any concerns they may have about people's care and felt these would be listened to. One person told us about an occasion when they had made a complaint, which they felt was dealt with promptly and to their satisfaction. However, some were unsure about the process for making a formal complaint because of recent management changes.

We saw that the displayed complaints procedure did not give the correct contact details for the manager and provider at the service. The details provided were those of staff no longer employed by the service. Records showed that complaints received about the service during the previous 12 months were investigated and acted on when required. Changes were made as a result of the investigation findings from three complaints, to help improve communication and personal care systems.

Requires Improvement

Is the service well-led?

Our findings

Management told us that regular checks were carried out of the quality and safety of people's care. This included checks of people's health status, care plans and medicines and checks of the environment and equipment used for people's care. They also included checks of staffing arrangements and nursing staffs' professional registration status. However, we found that the provider's checks of the quality and safety of people's care were not always effective. They did not identify whether their arrangements for the prevention and control of infection, including cleanliness and hygiene at the service were sufficient to protect people from the risks of receiving unsafe care. They also did not determine further improvements needed that we found during our inspection. For example, in relation to emergency procedures, consent, people's nutrition and staff responsiveness.

Records of the provider's external management checks showed that their system for checking the quality and safety of people's care had not been consistently followed during the latter quarter of 2015, which placed people at risk. Checks relating to people's health status were not consistently maintained or monitored to identify trends or patterns that may inform improvements that may be needed for people's care. This included checks of people's nutritional status and checks of risks from infection and falls. People's health and safety had been placed at risk as relevant checks had not been carried out.

Following subsequent management changes a new manager and clinical lead were appointed in January 2016. At our inspection we found the manager had undertaken a number of recent checks of the quality and safety of people's care. This included some checks of the environment and equipment used for people's care and checks of medicines and related staff training. The checks showed that some improvements were needed in relation to the environment, but action plans from this were not fully considered. This showed that the provider failed to act on information to improve the quality and safety of the service.

Since our last inspection, the provider had made improvements to quality and safety of people's care. This included their arrangements for people's medicines and staffing improvements at the service. However, their action plans to improve the service were often initiated or requested by local authorities following their visits to check people's care and safety or the safety of the environment. For example, local health and social care commissioners and the local fire authority. This meant the provider was not always pro-active in determining improvements that may be required for people's care.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The provider had not always sent us written notifications about important events that happened in the service when required or until we asked them to. For example, notification about provider changes; or following a serious untoward incident that remains subject to an investigation by an external authority.

People, relatives and staff told us that the new manager was 'approachable' and 'open to listening to their suggestions or concerns. For example, one person said, "She is very helpful." Most told us they had seen

some improvements during the previous month in relation to the organisation and delivery of people's care, but felt that further improvements were needed in relation to this and also the environment.

However, none of the people we spoke with or relatives had been formally asked by management or the provider for their views about their care. The manager told us that written survey type questionnaires were used to obtain this, but that people's views had not been formally sought in this way for some time. There were no other arrangements in place for people, their relatives or visiting professionals to give confidential feedback about the care service. This showed that people's views or the views of others with an interest in their care, were not routinely sought to inform people's care. This was contrary to the provider's own statement of purpose and service information provided for people and their relatives.

Staff praised the manager and said they felt able to raise concerns or make suggestions about improving people's care. One staff member said, "Fantastic; she gets onto things straight away. Another told us, "We can go to her at any time, she listens and she's supportive."

Staff mostly understood their roles and responsibilities for people's care and senior management and nursing staff were visible and available to them. Minutes of the manager's recent meetings held with all staff groups showed their instructions about expected care standards and some improvements needed. This included arrangements for organisation and timely delivery of people's care and for their meals and drinks. They also included a revised system to help improve communications relating to people's care and health needs and related changes. This helped to make sure that staff fully understood their roles and responsibilities for people's care.

Other communication and reporting procedures were in place to help staff raise concerns or communicate any changes in people's needs. For example, procedures to be followed when accidents occurred or when there were any changes in people's health conditions or safety needs. The provider's procedures also included a whistle blowing procedure. Whistle blowing is formally known as making a disclosure in the public interest. This helped to promote an open and transparent culture, where staff were supported to raise concerns about people's care if they needed to.

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 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment. The registered person's arrangements for the prevention and control of infection in the home did not fully protect people from the associated risks of unsafe care. Regulation 12(1) and (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 – Good governance. The registered person's arrangements to assess and monitor the quality and safety of services and to assess monitor and mitigate the risks relating to people's health, safety and welfare were not always operated effectively. Regulation 17(1) and (2) (a) and (b).