Nationwide Healthcare Limited

Ashwood Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 10 November 2015 and was unannounced. This meant that the provider did not know we would be visiting. A second day of inspection took place on 12 November 2015, and was announced. The service was previously inspected on 12 and 16 March 2015, and was not meeting six of the regulations we inspected.

Ashwood Lodge is a 27 bedded care home providing residential care. The service does not provide nursing care. The home is a converted building, with all of the communal areas and bedrooms situated on the ground floor. At the time of the inspection 20 people were using the service, 14 of whom were living with dementia.

There was a registered manager in place. 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.

Summary of findings

There was a safeguarding policy in place that contained detailed guidance on possible types of abuse. Staff received training in safeguarding and felt confident in reporting issues should they arise.

Risks to people were assessed and minimised. Deficiencies in the premises had been remedied since our previous inspection though the building was in need of redecoration.

People were supported by staff who had been appropriately recruited and inducted.

The service had up-to-date policies and procedures in place to safely manage medicines and people had their own documents showing how their medicines should be used.

Staff received suitable training to ensure that they could appropriately support people. Some training was overdue but there was a plan in place to address this. Staff said they received sufficient training to do their jobs.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Standards to ensure that people received care that they consented to or was in their best interests.

People received suitable support with food and nutrition and were able to maintain a balanced diet. Mealtimes were enjoyable for people using the service.

The service worked with external professionals to support and maintain people's health. The professionals we spoke with had no concerns about the service.

Staff treated people with dignity, respect and kindness and were knowledgeable about people's needs, likes, interests and preferences. People had access to advocacy services.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received. External professionals thought that staff knew the people they were supporting well.

People did not have access to a wide range of activities, which meant that they sometimes felt socially isolated. This prevented them from maintaining relationships and links with their community.

The service had a clear complaints policy that was applied when issues arose.

The registered manager used audits to monitor and improve standards. The provider undertook site visits to review service quality.

Staff felt supported and included in the service by the registered manager. However, staff did not feel supported by the provider. The registered manager said they felt supported by the provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Risks to people were assessed and minimised. Deficiencies in the premises had been remedied since our previous inspection.

People were supported by staff who had been appropriately recruited and inducted.

The service had up-to-date policies and procedures in place to safely manage medicines, but some recording errors were still occurring.

Good

Is the service effective?
The service was effective.

Staff received suitable training to ensure that they could appropriately support people. Mandatory training was completed and there were plans in place to ensure staff received regular refresher training.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Standards.

People received suitable support with food and nutrition and were able to maintain a balanced diet.

The service worked with external professionals to support and maintain people's health.

Good

Is the service caring?
The service was caring.

We observed staff treated people with dignity, respect and kindness.

Staff were knowledgeable about people's needs, likes, interests and preferences.

People had access to advocacy services.

Good

Is the service responsive?
The service was not always responsive.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received.

People did not have access to a wide range of activities, which meant that they sometimes felt socially isolated.

The service had a clear complaints policy that was applied when issues arose.

Requires improvement

Summary of findings

Is the service well-led?

The service was not always well-led.

The registered manager used audits to monitor and improve standards.

Staff felt supported and included in the service by the registered manager. However, staff did not feel supported by the provider.

The registered manager understood their responsibilities in making notifications to the Commission.

Requires improvement

Ashwood Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 10 November 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 12 November 2015 and was announced.

The inspection team consisted of an adult social care inspector and a specialist advisor.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with six people who lived at the service and two relatives. We looked at four care plans, and Medicine Administration Records (MARs) and handover sheets. We spoke with nine members of staff, including the registered manager, the deputy manager, a senior carer, five care assistants and members of the domestic and kitchen staff. We also spoke with two external professionals who work with the service. We looked at four staff files, which included recruitment records. We also completed observations around the service, in communal areas and in people's rooms with their permission.

Good

Is the service safe?

Our findings

At the last inspection on 12 and 16 March 2015, we asked the provider to take action to protect people from the risk of improperly maintained premises, from the risk of inadequate hygiene and infection control, from the risk of abuse and improper treatment and from the risk of working with staff who were unsuitable. This action had been completed.

We saw that a number of improvements to the maintenance of the premises had been made. A bathroom had been renovated, which included removing a damaged bath and replacing rusty bathroom furniture. The flooring in the laundry and sluice areas was replaced, and the rooms repainted. The plumbing in the sluice room was replaced, which meant it no longer leaked. A piece of defective stand aid equipment was no longer in use, and the registered manager told us that the weigh scales were recalibrated in May 2015 and were going to be replaced. Doors that should be secured for safety reasons (for example, to the boiler room and laundry room) were locked, and corridors and communal areas were kept free of equipment and other tripping hazards. During our inspection external roofing contractors visited the service to repair a leaking room.

Records showed that fire alarms, emergency lights and the nursing call system were checked on a monthly basis. A fire hazard assessment had been renewed in March 2015, and each area of the building had its own assessment. Seven fire drills had been completed since March 2015, including during the night shift. Maintenance staff carried out monthly checks of water temperatures, hand rails and emergency lighting. The registered manager said, “In June every year we have a company come in to check everything. The [maintenance staff] also do monthly checks.” Required certificates in areas such as PAT electricity testing, hoist tests, gas safety and legionella were up to date. This meant that potential risks to people’s safety in the premises were assessed, managed and reviewed.

Throughout the inspection we saw domestic staff undertaking various cleaning tasks, including of communal areas, bathrooms and people’s rooms. The service looked clean and was free of unpleasant smells. Equipment looked clean and tidy. Bathrooms and the laundry room had cleaning charts displayed, and these were up to date. The treatment room and medicine trolley were clean and orderly. Bins were pedal operated and had bin liners. However, we did see that alarm cords in bathrooms did not contain any plastic coating and that some looked dirty. Also some bathrooms had ‘Cleaning in Progress’ signs stored in them which were a potential tripping hazard. We spoke with the registered manager about these and they undertook to ensure they were rectified.

The sluice room was still accessed through the laundry, but we saw that staff doing this used seal bags to transport material and reduce the risk of waste contaminating clean areas. Dirty laundry was stored in a covered basket in the corner of the sluice room. Clean laundry was taken to a room away from the sluice to be sorted and ironed. Bathrooms had signs encouraging people to wash their hands, and we saw staff doing this before they assisted people. Training records showed that all staff had either completed mandatory infection control training or that training was arranged.

One person told us, “I feel safe living here.” Care plans we looked at contained individual risk assessments. These covered areas such as skin integrity, pressure sore risk, nutrition, oral health and mobility. A ‘personal safety’ risk assessment was also undertaken. The assessments were reviewed on a monthly basis which meant risks had been identified and were being managed to keep people safe. Accidents and Incidents were clearly recorded, and a log was kept of remedial action taken. For example, one person had a fall in October 2015 and this led to a referral to the falls team. The registered manager analysed accident and incident records every month to look for trends.

There was a business continuity plan in place dated 2015. This contained guidance to staff on dealing with a number of emergency situations, including useful contact details. Arrangements had been made with a nearby to provide continuity of care and emergency accommodation. There were also specific personal emergency evacuation plans (PEEPS) in place which included information on people’s care needs, mobility and any other relevant information. These had been last reviewed in 2015. This meant that people would receive appropriate support in emergency situations.

The service had a safeguarding policy, which the registered manager said had been revised since our March 2015 inspection. The policy contained guidance on potential

Good

Is the service safe?

sources of abuse, how to recognise signs of them and definitions and descriptions of different types of abuse. It also contained details of who to report suspicions to, both internally within the service and to external bodies such as the local safeguarding team, the police and the CQC. The policy was not signed or dated but the registered manager said that it was in use. Staff had a good working knowledge of safeguarding issues and could describe the types of abuse to look out for. One said, "I am aware of the policy and if I had any concerns I would go straight to the manager." Another said, "I know the policy. We always hear about safeguarding." The registered manager said, "There have been safeguarding incidents since the last inspection. I put them through to [local authority safeguarding] but they weren't substantiated." We saw that incidents had been investigated and notified appropriately. The registered manager reviewed the notifications every month to look for trends.

We looked at the management of medicine and observed a medicine round. People were assisted to take their medicines in a gentle, supportive and unhurried manner. Some people chose to have their medicine left with them to take with breakfast. Administering staff only signed the medicine administration record (MAR) when they saw that medicines had been taken. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Each person had a document in place showing how their as and when required medicines should be managed (a 'PRN protocol') and amount of medicines they had used. Controlled drugs were stored and managed safely and legally. Controlled drugs are medicines that are liable to misuse.

Staffing levels were determined by the registered manager. They said, "I did have a tool but it came out as overstaffed so I don't use a tool now. Now I do it as needs led. I review it all the time, for example when the number of people living here changes. A few weeks ago we were down to 16, but now we are up to 20." Day staffing (during the week and at weekends) levels were a senior carer and two carers working from 8am to 8pm. A third carer worked from 9am to 5pm. Night staffing levels (during the week and at weekends) were a senior carer and carer working from 8pm to 8am. Staff rotas confirmed those staffing levels. The registered manager said, "We are recruiting for bank staff. We don't have bank staff at the moment, and have never had a major problem covering shifts. We have used agency staff once, and as a rule the day and night staff cover each other's rotas. I think we have enough staff. We have struggled sometimes with sickness but that is the same as everywhere else." Staff told us that they were busy but that there were enough staff to support people. One said, "There have not been enough staff on shift. We only recently had a 9am to 5pm carer, which has helped. We were going home knackered. I think people picked up on it as they'd say we were rushed off our feet, but I don't think it impacted on care." Another said, "There wasn't enough staff on shift but we've just got 9am to 5pm help and that has made a real difference. Normally meal times are busiest but that's all covered now. We not long ago used agency staff but we like to pitch in when we can." One person said, "I would like more time with the staff but they are very busy." One relative said, "the staff work so hard." During the inspection call bells were answered quickly, and we saw that people were supported promptly.

The registered manager said that the recruitment process had been reviewed and changed with support from the provider since the last inspection in March 2015. One member of staff had been recruited using the new system. An application form detailed their employment history and interview notes showed that they had been asked questions about their motivation, competences and knowledge. Two written references were obtained in advance of their interview, including from their most recent employer. A Disclosure and Barring Service check was undertaken before their employment commenced. Their staff file contained photocopies of two pieces of photographic identification and a contract of employment. The registered manager said that all staff had now undergone DBS checks, including for three staff who did not have them at the time of the March 2015 inspection. Records confirmed that the checks had been undertaken. This reduced the risk of people being cared for by unsuitable staff.

Good

Is the service effective?

Our findings

At the last inspection on 12 and 16 March 2015, we asked the provider to take action to protect people from the risks of their legal rights relating to capacity and consent and to access to timely care and treatment not being protected. This action had been completed.

The manager and staff we spoke with told us that they had attended training in the Mental Capacity Act (MCA) 2005. MCA is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. They had not only ensured that where appropriate, Deprivation of Liberty Safeguard (DoLS) authorisations had been obtained. The manager clearly understood the principles of the MCA and 'best interest' decisions and ensured these were used where needed.

Staff had a good working knowledge of the Mental Capacity Act. One said, "It's for people who don't have capacity to make decisions that they can't. It's about doing things in their best interests. For example, one person here doesn't have capacity and doesn't like to eat. We still give them the option and ask them even if they don't have capacity because some days they can answer." We found that staff understood that when people had capacity they could make unwise decisions and how to complete decisions specific capacity assessments. The manager had recognised this gap and outlined that they were sourcing additional training. Plans were in place for staff to complete other relevant training such as how to apply the Mental Capacity Act 2005 principles, how to complete capacity assessments and record 'best interest decisions'. Covert medicines were appropriately recorded and paperwork was completed by GPs after consultation with people's families and the multi-disciplinary team. This meant that people's capacity and rights were being considered and protected by the service.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager was aware of DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. DoLS had been sought and authorised where appropriate.

Care records we looked at showed that the service helped people to get help with maintaining their health from external professionals. In one care plan, visits from the occupational therapist and district nurse had been recorded and an entry read, 'spoke with GP re: nutrition.' In another, we saw that the person was receiving regular visits from the district nurse in relation to pressure damage care. In a third, a person tripping over led to a referral to the falls team. This meant that people were supported by the service to access the health care and support that they needed.

We looked at the training matrix, which is a document used by management to monitor the training staff have completed. The registered manager told us that staff received annual mandatory training in fire safety, food hygiene, moving and handling, health and safety, safeguarding, infection control, safe handling of medicines, equality and diversity, the Mental Capacity Act, end of life care and dementia awareness. Mandatory training is training the provider has deemed necessary to care for people safely. The training matrix showed that most mandatory training was up to date, with staff having either completed training or with training arranged.

However, the training matrix also showed that some staff had not completed mandatory training and no training was arranged for them. For example, two members of staff were overdue dementia awareness training. The registered manager said, "That training is done at Stockton Sixth Form College and we are only allocated so many places, so I've concentrated on care staff… I have also put [kitchen staff] through it as they are a bit more hands on at meal times." The registered manager kept a record of who had completed mandatory training. This showed that only 68% of staff had completed first aid training, but we saw those who were overdue were booked onto a course in January 2016. Our judgment was that the registered manager had a plan in place to ensure staff received mandatory training. Additional training was offered in care planning, early warning signs, diabetes, mental health, stroke awareness and nutrition. We saw that five members of staff had signed up for optional diabetes awareness training. One member of staff said, "The training is good. I think we get enough." This meant that staff received the training they needed to support people.

Staff were supported with their professional development through supervisions and appraisals. The policy was that

Good

Is the service effective?

staff received four supervisions and one appraisal annually. Records confirmed that this was taking place. Four staff were still awaiting their annual appraisal, but the registered manager said these would take place before the end of the year. Appraisal records showed that staff were asked about their personal objectives and training needs, and the registered manager told us they monitored any actions arising from them. One member of staff said, "We get supervisions and appraisals, which are good. You can express yourself and how you are feeling." Another said, "They're alright, actually, as I've requested additional training in strokes and diabetes. They do listen to us." The registered manage received supervisions and appraisals from the provider, and records showed that three had taken place in 2015 at which a broad range of issues had been discussed. This meant that the service was monitoring staff competency and knowledge in the delivery of their roles.

People were supported to maintain a healthy diet. In between the set meal times people were offered snacks and hot and cold drinks. Everyone chose to eat in the dining room, which had a relaxed and convivial atmosphere during mealtimes. A large notice board on the wall contained the daily menu and information such as the local weather forecast and a 'quote of the day' which people appeared to enjoy reading. However, staff did comment that the green ink used may not have been visible to everyone in the room. Tables were set with cutlery and condiments before people arrived, which gave the room a homely atmosphere.

Meals were plated up in the kitchen and passed through a hatch to the dining room. People's dietary and nutritional needs were displayed in the kitchen, for example, people who were diabetic or who were at 'high nutritional risk'. This meant that people received food that was appropriate to their needs. Staff also ensured that personal preferences were catered for. Where appropriate, they asked people what sized portion they would like. In another case, we saw a person ask if they could have some gravy taken off their plate as their meal was "swimming in it." This was quickly replaced with a new meal with less gravy. Staff were attentive to people as they ate. When some people started to squint in the sunlight, staff asked everyone in the room if they could close the blinds and explained why. Where people needed support to eat, this was done patiently and with kindness. People were encouraged to eat discreetly and respectfully. Staff helped people to maintain their independence by prompting them try to eat themselves before stepping in with support. We saw staff assisting one person who was living with dementia, who was reluctant to eat. Staff recognised why the person was not eating and identified an alternative meal that they enjoyed. This led the person to kiss the staff member who was assisting them on the cheek before going on to finish their meal. One person said, "The food is good here. We get a choice of two and decide when we get here, or sometimes they come around in the morning and ask. And the menu is on the wall." Another said, "The food is good. I enjoy my breakfast."

Good

Is the service caring?

Our findings

Throughout the inspection we saw examples of staff treating people with dignity and respect. One member of staff said, "Everyone is treated in their own, individual way and with respect." Staff knocked on people's doors and waited before entering rooms. Where people asked for support this was done discreetly, with staff encouraging people to do as much as they could for themselves. If staff needed to discuss a person, we saw that they moved away from communal areas so that this could be done privately. One member of staff said, "We always close curtains and doors if getting people ready. We also ask about things like do they want lipstick on." Another said, "We always try to encourage people to be independent. For example, one person can stand up but sometimes they give up. We encourage them by saying you can do it! Or when helping people with food, we put food on their fork and give it to them to eat before giving more support if needed." A third said, when talking about supporting people living with dementia, "I make an effort to talk to people whenever I can. Talking helps to reassure people. I always try to speak calmly but never speak to people like they're babies."

Staff interacted with people as they were moving around the building, and made time to stop and talk to them. Staff knew people well and were able to discuss their families and lives, and we saw that people enjoyed this. Staff also spoke with visiting relatives, and we saw that helped them to get to know the people they were supporting. One member of staff said, "The best thing is the reward of caring and getting to know each resident." Another said, "I enjoy it and love looking after the residents." One person said, "the [staff] are lovely and they keep me cheerful." A visiting relative said, "We were not happy with other placements, tried a few but the care was lacking, the care here is excellent, the staff obviously care and work so hard…the staff are superb." We saw a compliment letter that had been written by a relative, which read, 'I would never have believed how caring people could be and the lengths they would go to to look after my [relative]. He was just another person to them but you would think he was their [relative], unbelievable…I go into that home every day and when I need to go into a home that is where I will go. I can't say any more than that.'

Staff were able to recognise and describe people's personal preferences. For example, they knew what time people liked to have a snack or hot drink and the type they preferred. They also had knowledge of their interests, and we saw staff talking to people about what they had watched on TV or what they would be doing with their families during visits.

People had access to advocacy services where appropriate. Advocates help to ensure that people's views and preferences are heard. The registered manager told us that one person used an advocate and was reviewing whether another person needed one.

Requires improvement

Is the service responsive?

Our findings

At the last inspection on 12 and 16 March 2015, we asked the provider to take action to protect people from the risks of unsafe care by maintaining accurate, complete and contemporaneous care records. This action had been completed.

The service did not employ an activities co-ordinator, and we observed that activities provision was limited. No activities were advertised or promoted. Some people told us that they went out to keep themselves occupied, and that staff assisted them to do this and sometimes accompanied them to do shopping or for a meal. One person said "I often go out on my own. I just tell [staff] I want to go out. [Staff] have taken me to the town centre and I have been for a meal and had one delivered." We asked staff if any activities would be taking place, especially for people who were less able to leave the service. We were told, "There are no activities this morning as people tend to sleep in the morning after breakfast. We will do nails this afternoon." Later in the day we saw staff engaging in ball exercises in the lounge, but people did not look engaged.

One person said, "I get very lonely. There are not many activities here that I know of." Another person, when asked about activities, said, "I like it here most of the time, but it can get a bit lonely. Time goes slow." A relative, when asked what could be improved in a visitor quality assurance questionnaire dated 17 May 2015, wrote, 'Activities. Not enough to keep [person] occupied.' One member of staff said, "People do get activities but don't always like them. We could do with more but there is no money to get things so we just have to do the best we can." Another said, "We do activities around 2.30pm. We do hands, nails, reminiscence and crisps and wine." We asked the provider about activities. They said, 'Outdoor and indoor activities have been provided to the residents. Provision for extra activity staff to assist residents for day visits to shopping centres and eating out have been made throughout the summer, in addition to the barbecues and outdoor activities at the home in the newly prepared outdoor enclosure. We have also invested in providing daily varied indoor activities such as armchair exercises, manicure, pedicure and nail painting, quizzes, card games, bingo, dominoes, skittles, movie days and sing-song by the activity staff and pet therapy by external agency.' During the inspection we did not see people engaging in activities except for ball exercises and singing. Our judgment was that people were sometimes socially isolated due to the lack of activities suitably tailored to their specific needs and interests.

This was a breach of Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans began with a personal profile, which used the Alzheimer's Society's, 'This is Me' booklet to record people's life history. People had care plans in areas including physical care, nutritional care, communication, continence and mobility. These contained information about the person's care needs, and how staff could best support them. We saw that these were reviewed regularly and where changes were observed care plans were updated to reflect this. For example, during a review of one person's physical care plan it was noted that reddened areas had been observed. The care plan was updated to include the use of a pressure cushion, increased staff support and visits by the district nurse to assist with pressure care.

Daily records of people's care were recorded electronically on the office computer, and were periodically printed off and attached to care plans. We asked the registered manager how staff accessed the most up-to-date information on people. They said, "The sheets are on the computer but we do have a file with daily records. We do try to keep paperwork down…but notes are printed off and put in the daily file. The file is also used at handovers." We saw staff accessing daily records, which meant that they were available when needed. A daily handover sheet was used to inform staff of any changes in people's needs from the previous shift. The sheet had an entry for each person, and a summary of their day. For example, on 4 November 2015 the sheet recorded, '[person] – contacted surgery with regards to script for antibiotics. [person] – DN attended to administer [medicine].'

We spoke with a nurse who works with the service, who said, "All the residents seem well cared for. Everything seems fine. You can ask staff questions about people and they seem to know people's needs." Another nurse who works with the service said, "[Staff] were always happy to work with us and always followed our care plans. They certainly got to know [the person] and did everything they could for them. For example, one person used to like to get outside and when their mobility started to deteriorate staff did everything they could to get [the person] out."

Requires improvement

Is the service responsive?

The service had a complaints policy, which was publically advertised and accessible in the reception area. It covered formal and informal complaints, as well as, 'grumbles to staff at the home.' The policy detailed who was responsible for investigating complaint and the procedure that would be followed. It also contained details of other agencies that people could complain to. 29 complaints were received between March 2015 and the date of our inspection. Records showed that the complaints policy had been followed to investigate these.

Requires improvement

Is the service well-led?

Our findings

At the last inspection on 12 and 16 March 2015, we asked the provider to take action to protect people from the risks of not implementing good governance of infection control and record keeping and acting on feedback from relevant persons to improve service. This action had been completed.

The registered manager sought feedback from people and their relatives using a 'quality assurance questionnaire'. People had used these to give feedback about the décor and general condition of the service. One said, from May 2015, in the section asking what improvements were required, 'décor, building looks very old.' A second from May 2015 said, 'Could be better. [Relative's] room needs new carpet and some paint.' Another, from June 2015, said, 'decor' and 'could do with a spruce up.' At the time of the inspection the environment was tired and worn out in places and in need of decoration and new furnishings and carpet. One member of staff said, "If I could I would decorate and upgrade the environment." Another said, "The building needs to be up dated and decorated, the handy man comes three days a week, he should be on site I think." The registered manager said, 'Décor is coming up all the time. It is difficult as the handyman is only here 18 hours a week and he has to do everything. There is a plan to repaint but it is going slowly and needs more than that. The kitchen and dining room also need doing. They were last done with paint 2 years ago.'

Staff were able to describe the culture and values of the service. One said, "It is a lively, nice place to work. The care is brilliant." Another said, "There is a lively atmosphere…everyone gets along." People felt supported by the registered manager and said they would be confident to raise issues with them. One member of staff said, "[The registered manager] is lovely and always supportive." Another said, "[The registered manager] is very flexible and caring." A third said, "[The registered manager] is approachable and I feel supported." However, staff felt less supported by the provider. One said, "I have not seen a lot of [the provider]. I have seen them four or five times since I started here and they didn't know my name. They could help out more. I think they could give more input and ask us what things we need to improve the home, like wallpaper…and activities." Another said, "The downside is we never see the owners. I haven't seen them since they took over." This meant that staff felt included and empowered by the registered manager but not always by the provider.

As part of our inspection we spoke with local authority commissioners. We received feedback that the local authority was working with the service and that they continued to have concerns about the support the provider was giving to the registered manager in improving the service. In addition, an external professional we spoke with said, "I was given the impression that the management were not given much support from the owners." We asked the registered manager about the support they received from the provider. They said, "When they come in they pick up the complaints file and have a look through it. I don't know when they're coming in. I put action plan together and they had the main input with the repairs. They have kept up with my supervisions. They did start to come in more but that has tailed off a bit. They helped with the recruitment process." The registered manager said they felt supported by the provider.

The registered manager was now working as a supernumerary manager and said they "rarely" covered care shifts. The staff rotas for the four weeks preceding the inspection showed that the registered manager had worked two twelve hour shifts as a senior carer. We were told that this was due to last minute sickness of other staff. The registered manager said that they felt they had more time to work on management and to put management and quality assurance systems in place.

The registered manager undertook a number of audits of the service. These covered areas such as catering, bedroom checks, housekeeping, mattresses, complaints, medicines and health and safety. Where issues were identified action plans were completed and remedial action taken was logged. For example, a catering audit on 10 July 2015 achieved a score of 70%. Anything less than 84% triggered a 'red flag – immediate action required.' In this case, a re-audit the following week was triggered to ensure that the issues raised had been addressed. The registered manager said, "I aim to do them every month. Some months they are quite comprehensive, then another month you will find not much is highlighted. Since the last inspection I do try to make them more informative. I have a file with all of my audits and have tried to make them more effective. I now have more time to do things."

Requires improvement

Is the service well-led?

The provider told us that they undertook site visits to monitor the quality of the service, and records confirmed that these had taken place in January, May, July, August, September and October 2015. During visits the provider spoke with staff and people using the service, inspected premises and care records and reviewed any complaints that had been submitted.

The registered manager understood her responsibilities. We noted that all relevant notifications concerning running the service had been made to the Commission.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not supported to maintain relationships or involvement in their community due to a lack of activities provision. Regulation 10(2)(b)