

Community Integrated Care

Green Heys Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

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 took place on 28 and 29 August 2018 and was unannounced.

Green Heys Care Home is registered to provide nursing and personal care for up to 39 people. At the time of the inspection there were 30 people living at the service. Green Heys is a purpose built single story building set in pleasant grounds and situated in a residential suburb of Liverpool. The service consists of two units and provides care to older people living with dementia. It has a large dining room, two lounges and areas of seating located in both units. There is a large family room equipped with a small kitchenette. People's visitors are able to stay over if so required. There is a pleasant garden area with outdoor seating and a sheltered area.

Green Heys is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the last inspection in January 2018, the service was found to be in breach of 'Safe, Care and Treatment' which was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities Regulations) 2014. This was because systems in place to manage topical medications and controlled drugs were not being properly managed. During this inspection we checked to see if improvements in these areas had been made and found that they had.

At this inspection, we found the service to be in breach of 'Good governance,' which was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities Regulations) 2014. This was because audits did not identify all of the concerns highlighted during this inspection. People's care records had not always been amended and updated to reflect their current health care requirements. For example, advice from external healthcare professionals had not always been incorporated into the main care plan and people's care records did not always record consistent information. We also found that people's personal emergency and evacuation plans (PEEPs) did not contain sufficient information. This meant that people were potentially at risk of exiting a building unsafely in the event of an evacuation or an emergency. We spoke to the registered manager about this and at the time of writing our report, the necessary work had been taken to rectify the information in people's care records and PEEPs.

We found that the recording of thickened fluids was not managed safely. Thickened fluids are used to reduce the choking risk for people with swallowing difficulties. We found that although Medication Administration Records (MARs) were in place for thickened fluids, the use of thickened fluids were not

recorded on people's input charts. We spoke to the registered manager about this. They amended the fluid input charts so that care staff were able to correctly record the use of thickened fluid. The registered manager implemented this change on the second day of our inspection.

During our inspection we found the environment to be in some need of refurbishment and decoration. Feedback from people living at the service and their relatives, about the cleanliness of the service, was that standards could be improved. We found that improvement was also needed in order to adapt to the needs of people living with dementia. We discussed this with the registered manager who told us about their plans to improve the environment in terms of cleanliness and decoration. You can see what action we asked the provider to take at the back of the full version of this report.

Each of the people we spoke with told us they felt safe living at Green Heys. Staff we spoke to understood their responsibilities in relation to safeguarding people from abuse and mistreatment and were able to explain how they would report any concerns.

Arrangements were in place with external contractors to ensure the premises were kept safe.

We found that medicines were managed safely. Medicines were stored correctly and were administered by staff who were competent to do so.

We looked at how accidents and incidents were reported in the service and found they were managed appropriately.

We looked at the recruitment processes which were in place. We reviewed records for three members of staff. We saw that each staff member's suitability to work at the service had been checked prior to employment to ensure that staff were suitable to work with vulnerable people.

We looked at care records belonging to eight people. We saw that people's care requirements were identified and people were appropriately referred to external health professionals when required. This helped to maintain people's health and well-being.

People and their relatives were involved in the formulation of their care plans. We saw that people's preferences were considered. Staff supported people in a person-centred way and treated them in a way which respected their dignity and independence.

Staff sought consent from people before providing support. Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) to ensure people consented to the care they received. The MCA is legislation which protects the rights of people to make their own decisions.

We found that there were enough staff on duty to meet people's needs. Interactions we observed between staff and people living at the service were warm and caring.

Staff treated people with respect and took care to maintain people's privacy, dignity and independence.

There was an open visiting policy for friends and family. There was a dedicated friends and family room so they could stay overnight to support their loved one if required. This helped people feel supported. For people who had no one to represent them, the service would support them in finding an advocate to ensure that their views and wishes were considered.

The service employed a part-time activity co-ordinator who facilitated varied daily social activities to keep people occupied and stimulated. The service had a monthly activities schedule which offered various activities from external providers.

We asked people what they thought about mealtimes and feedback was positive. An external catering service supplied a wide range of nutritious meals. People told us they had choice and could have an alternative if they did not like what was on the menu. We spoke to staff who were knowledgeable about people's preferences and dietary requirements.

The service had a complaints procedure in place and both people we spoke with and their relatives told us they would feel comfortable in raising any concerns they had with the manager. Complaints were recorded and acted upon appropriately.

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.

Care records were not up to date to enable risk to be monitored and mitigated.

Checks were in place to ensure the premises were safe.

Medicines were managed and administered safely in the service.

Staff were recruited safely.

Is the service effective?

Good ●

The service was effective.

We found that Deprivation of Liberty Safeguards applications had been made appropriately and consent was sought in line with the principles of the Mental Capacity Act 2005. Staff were knowledgeable in their understanding of supporting people when they lacked capacity to make informed decisions.

Staff were well supported in their role through training and regular supervisions.

Staff were knowledgeable about people's dietary requirements and preferences.

Is the service caring?

Good ●

The service was caring.

Interactions between staff and people living in the home were positive. People told us staff were kind.

We observed people's privacy and dignity being protected during our inspection.

Family and friends could visit when they chose.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care records did not always contain current and consistent information about people's healthcare needs.

Staff were knowledgeable regarding people's care needs and preferences.

Systems were in place to gather feedback from people and listen to their views. People knew how to make a complaint if needed.

Is the service well-led?

This service was not always well led.

The service completed a range of audits in relation to quality and safety, but they had not always been effective in identifying concerns.

There was an extensive set of policies and procedures to provide staff with guidance.

Feedback regarding the overall management of the service was positive.

Requires Improvement 

Green Heys 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 checked 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.

As the provider had a rating of 'Requires Improvement' at the last focused inspection and was in breach of Regulation 12 of the Health and Social Care Act Regulated Activities Regulations 2014 (Safe Care and Treatment), we were required to re-inspect the service within six months to check if any improvements had been made.

This inspection took place on 28 and 29 August 2018 and was unannounced. The inspection was conducted by an adult social care inspector 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.

Before the inspection we checked the information we held about both the service and the service provider. We looked at any statutory notifications received and reviewed any other information we held prior to visiting. A statutory notification is information about significant events which the service is required to send us by law. A Provider Information Return (PIR) was also submitted and reviewed prior to the inspection. This is the form that asks the provider to give some key information in relation to the service, what the service does well and what improvements need to be made. We also invited the local authority commissioners to provide us with any information they held about the service. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the quality audit manager, four members of care staff, one nurse, one member of domestic staff, one member of kitchen staff and one person who lived at the service. Due to their health conditions, most of the people living at the service were unable to speak with us, so we undertook general observations of the service and the care people received. We used a number of different methods to help always understand the experiences of people who lived at the home. For example, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help understand the experience of people who could not talk to us. We also spoke to

seven relatives of people using the service to gain a better understanding about their relative's experience of care at Green Heys.

We looked at care records belonging to eight of the people living at the home, three staff recruitment files, a sample of medication administration records, policies and procedures and other documents relevant to the management of the service. We also undertook general observations of the service over the course of our two-day inspection.

Is the service safe?

Our findings

At the last inspection we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). This was because we found some concerns around the processes in place governing the use of topical medicines and controlled drugs.

During this inspection, we looked at systems in place for managing topical medication and controlled drugs to see if improvements had been made and found that they had. The provider was no longer in breach of Regulation.

We saw that topical medicines were recorded correctly and given as prescribed. We also saw that body maps were used to help staff identify the correct part of the body where the medicine was to be applied.

We looked at how controlled drugs were handled. At the last inspection we found that staff did not always comply with the medication policy in place around controlled drugs. Controlled drugs are subject to the Misuse of Drugs Act and associated legislation and so require extra checks. At this inspection we saw that improvements had been made. Controlled drugs were kept securely in a locked cupboard. We checked the stock balances of a selection of controlled drugs and found them to be correct. We also checked to see if they had been signed out by two members of staff before being given and found that they had. The service performed a daily stock balance of controlled drugs, this was good practice as it reduced the risk of medication errors.

We looked at how thickening agent was managed. Thickening agent is prescribed for people with swallowing difficulties to prevent them from choking. We saw that although staff were aware of how much thickener to add to people's fluids, it was not being recorded appropriately on people's fluid input charts. We spoke to the registered manager about this who amended the input charts and instructed staff to correctly record thickener using the amended charts.

We looked at systems in place for monitoring environmental risk in the home. Firefighting equipment was maintained and people had a personal emergency evacuation plan (PEEP) in place. We found that PEEPs did not always provide enough detail about people's mobility status. This meant that staff and emergency personnel didn't always have important information on people's needs in an emergency situation, and the support they required to evacuate in the event of an emergency. We spoke to the registered manager about this who told us that PEEPs would be amended as a matter of priority. At the time of writing our report amendments had been made to people's PEEPs to rectify our concerns.

Feedback about the cleanliness of the service was mixed. One person we spoke with told us, "The home is spotlessly clean at all times." Another said, "It is very clean and there are never any nasty smells." A relative we spoke with told us, "I feel that some cleaning needs to be done early evening as bins can be over flowing." Two relatives we spoke with told us they felt the service needed, "A bit of a tidy up and new paint." We spoke to the registered manager about this who confirmed they would review the domestic staff's

cleaning schedules and would increase their hours per day if necessary to improve standards of cleanliness within the service. They also told us that a 'deep clean' of the service was planned imminently.

We found that medicines were stored safely and managed appropriately. Medication was stored in a locked clinic room which was kept clean and tidy. The clinic room was of adequate size and had hand washing facilities. The temperature of the room and the medication fridge was recorded daily to ensure it was within a safe limit. This is important as if medication is not stored at the correct temperature it may not work as effectively.

We saw that one person had a covert medication plan in place so that medicines were disguised in food or drink without their knowledge. This meant that although the person refused their medication it was vital to their well-being. We saw that this decision had been made with the input from the GP and pharmacist and had been made in accordance with the person's best interests, as the person did not have the capacity to understand the consequences of not taking their medication.

We saw that PRN (as and when required medication) protocols were in place for some medicines to help ensure people received their medication when needed, for example pain killers. The service also used nationally recognised pain scales to determine people's level of pain before administration of any pain relieving medication. This was good practice as it meant that people were not being given medication unnecessarily. People and relatives, we spoke with told us they received their medication on time, one relative said, "They receive medication by the staff and all at the appropriate time."

A medicine policy was in place to advise staff on the provider's medication policy and procedures. Nationally recognised best guidance on the administration of medication was also available.

We spoke to people who told us they felt safe living at the service, one person told us, "I feel safe because there is always someone here I can call on." Comments from relatives included, "If I didn't feel that they were 100% safe I would not be leaving them here," "Absolutely safe, they are on a one to one so I know they are much less likely to have falls," and, "I leave in the knowledge [relative] is in a safe environment and no chance that they can wander out of the building."

Although people had their own call bells, not everyone had the ability to use one. We saw that for people who were not able to use a call bell, additional safety measures were in place such as regular checks and 'walk rounds' of the service. However, we observed that during some busy periods of the day, such as the morning, people were not always supervised. One person told us, "When I need the toilet I am sometimes left to wait a long time which makes me uncomfortable." We spoke to the registered manager about how the service was staffed and how they were deployed.

Some of the relatives we spoke with felt there wasn't always enough staff, comments included, "More staff are needed; the staff here go above and beyond their duties," another said "I come at various times of the day and evening. I find evenings are short staffed."

We looked at staff rotas for the last four weeks and found that, as the service was not at full capacity, there was enough staff to meet people's needs. The service also used a dependency tool to help ensure there was a sufficient number of staff on duty at any one time. During the day there was one qualified nurse, two advanced carers, nine care staff, one clinical lead and the registered manager. In addition, there were two domestic staff, one kitchen assistant and usually an activity co-ordinator. At the time of our inspection the activity co-ordinator had been absent from the service since May 2018 but a second activity co-ordinator had been recruited and was due to commence employment the following week.

We looked at how staff were recruited within the service. We looked at three staff personnel records to check that appropriate checks had been carried out to ensure they were safe to work with vulnerable people. We saw that previous employer references had been obtained prior to employment and criminal conviction checks had been made. There were systems in place to ensure that qualified nursing staff were validated with The Nursing and Midwifery Council (NMC). The NMC is the professional regulatory body for nurses and midwives in the UK.

We spoke to staff to check their understanding around safeguarding people from abuse, maltreatment and neglect. Training records showed that staff had received training in this area and staff we spoke with were aware of the procedures in place to follow regarding any suspicion of abuse. Staff we spoke with told us they would not hesitate to report any concerns or signs of mistreatment or abuse. One staff member told us, "I would tell the nurse or the manager if I saw anything. I know that I could also tell CQC."

We looked at eight care files and records which showed evidence of a range of risk assessments and tools used to help keep people safe. Care files included individual risk assessments for areas such as moving and handling, falls, choking and nutritional risks. Assessments were regularly reviewed.

Staff had access to personal protective equipment (PPE). This is equipment used to help reduce the spread of infection. Regular audits were carried out in relation to infection control measures and any issues of concern were identified and acted on. The service employed two domestic staff who worked at the service Monday to Friday. At the weekend there was one domestic staff on duty.

External contracts were in place for gas, electric, fire safety and legionella. Records also confirmed that gas and electric appliances had been tested and were compliant. Additional checks and audits were completed such as water temperature, automatic door closure devices, fire alarms and call bells. The service employed maintenance persons to help maintain the internal and external parts of the home.

We looked at accidents and incident reporting within the service and found they were recorded in sufficient detail and managed appropriately. Any accidents and incidents were recorded on an internal database by staff and an email alert was raised to the registered manager who reviewed and analysed them for any trends or patterns. This information was then used to further improve people's safety, for example, by making referrals to other health professionals such as the falls risk team or implementing changes to people's care plans and risk assessments.

There were varied forms of communication within the service. Daily handovers took place so that any accidents and incidents which had occurred were discussed. During these handovers the health and well-being of people living at the service was also discussed. Both care and nursing staff recorded daily notes and there were communication books for both units so that staff were kept up to date with people's current health status. This helped to ensure safe practices.

Is the service effective?

Our findings

We looked at the care records for eight people. Records showed care plans which reflected people's personal preferences in relation to their care. For example, people could choose whether to have a bath, shower or a body wash and what time of day to have this. People could choose the gender of their care staff. Care records also contained a detailed pre-admission review so that people's key health care requirements were identified and could be met from the time they arrived at the service.

We saw that people were referred to external health care professionals appropriately, this included the GP, speech and language therapists (SALT), opticians, podiatrists, district nurses, physiotherapists and occupational therapists. This ensured that people's health needs were met and helped to preserve their overall wellbeing.

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

We looked at people's care records and saw evidence that people's capacity to consent was assessed appropriately in relation to a range of decisions. Where people are not able to consent, they 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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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.

We looked at the records for eight people who had DoLS authorisations in place. We found there was an effective process to record any restrictions in the best interests of people living at the home. There was also evidence of best interest decisions being made with input from people's relatives. For other people, we saw evidence of relatives having the appropriate legal status to make important decisions on behalf of their relative living at the service.

Care records we looked at contained information on how staff supported people with their dietary needs. Records also demonstrated that people were weighed regularly to ensure that people were not losing or gaining weight inappropriately. Both care staff and kitchen staff we spoke with were aware of people's individual dietary requirements.

An external catering company provided the service with its meals. Most people we spoke with told us they enjoyed the food and were offered a good choice of meals. Comments included, "The food is very good with plenty of choice," and, "If I did not like what they offered I would be given another choice. I feel there are

plenty of vegetables but not quite enough of the main fish or meat. I do not see a menu I just get asked [what I want] when I sit down to eat." One person told us they got plenty of snacks and drinks throughout the day and was offered a milky drink in the evening but liked a cup of tea.

People we spoke with felt that staff had the knowledge and skills to meet their needs, one person told us, "I had a problem with my mobility and had to be assisted to get up. They [staff] tried me with a stand aid, then tried with a hoist, I did not like either. They eventually used a belt which I am happy with. They took time and patience until it was right for me."

Employment records showed that staff members received regular supervisions to support them in their job role. Supervision enables management to monitor staff performance and address any performance related issues. We saw that the registered manager not only encouraged staff to discuss issues they felt important to them in addition to their professional development, but also discussed important matters such as safeguarding, whistleblowing, infection control and the Mental Capacity Act. This ensured that staff were kept up to date with current guidance and was good practice.

The registered manager provided us with information on staff training. We saw that training was provided in a range of health and social care topics such as moving and handling, fire safety, first aid, safeguarding and cardio pulmonary resuscitation (CPR). Some staff had received training in more specialist areas such as dementia care, pressure area care (React to Red) and MAPA (Management of Actual or Potential Aggression). A large number of staff had completed external courses in care such as National Vocational Qualifications (NVQs) and Advanced Practitioner courses. These qualifications were funded and encouraged by the service.

Although all of the staff had completed mandatory training, a small number of staff had not updated this training. We discussed this with the registered manager who told us that gaps in training had already been identified and refresher training had been organised. We saw that staff were provided with their own login details to access training courses and other relevant information online. Induction training for staff was based on the Care Certificate. The Care Certificate was introduced by the Government in 2015. This is a set of standards that social care and health workers comply with in their daily working life.

During our inspection we looked at people's bedrooms and saw evidence that people could personalise them. For example, some people had brought in their own items of furniture, others had framed family pictures on the walls. All bedrooms had had an en-suite facility. One relative we spoke with told us, "The room is just like being at home surrounded by their [relatives] own furniture."

The service was based on one level and so was easy for people to move around. However, we did note that some cosmetic improvement was required. The décor in some parts of the service appeared tired and worn. In addition, the environment required further adaption to make it more suitable to the needs and requirements of people living with dementia, in line with current best practice guidance, for example, NICE (National Institute for Health and Care Excellence). NICE provides national guidance and advice to improve health and social care. We spoke to the registered manager about this who told us they had plans to further develop both the indoor and outdoor space to make it more dementia friendly.

We saw that bathrooms had recently been refurbished. Although people had access to a shower over the bath, there wasn't a separate shower facility. During our inspection we saw that work was being undertaken to create a 'wet room'.

The service has a pleasant and enclosed outdoor space which people assessed in the summer months. We

spoke with the registered manager about plans to further develop this space with the use of sleeper beds and potting plants to create a 'sensory' garden and encourage people to engage in gardening.

Is the service caring?

Our findings

People living at the home and their relatives told us they were satisfied with the service and how well staff cared for them. One person told us, "The staff are 100% kind and friendly with me. Could not ask for better."

All of the relatives we spoke with spoke positively about the way the staff dealt with their relative. Comments included, "The staff are very kind and patient with my relative. They come and deal with them right away," "They are very good with my relative. They have got to know their little habits quickly which is nice," "You can't fault the staff. They are so kind and patient with all the residents at all times," "My relative is always clean and tidy, always shaven and always looks cared for," "They [relative] are safe and loved by the staff," and "The staff are always happy and smiling. This makes for a nice atmosphere and it makes the residents happy."

We carried out a Short Observational Framework for Inspection (SOFI) and found positive and warm interactions between staff and people living at home. People were treated respectfully and in a manner appropriate for their needs and level of independence. We also observed the delivery of care at various points throughout the day. We saw people were comfortable and relaxed with staff and it was clear that staff knew the needs of the people they were caring for well. Staff spoke to people using their names and took opportunities to talk to them when they could. They also engaged in physical contact such as hand holding and placing their arm around shoulders.

We observed staff support people in a way that maintained their privacy, dignity and independence. For example, staff would discreetly ask people if they required assistance by whispering in their ear. We observed staff closing doors to bathrooms and people's bedrooms when delivering personal care. One person told us, "The staff are very good and treat me with dignity at all times. They help me have a bath and I always have a female carer by choice."

Comments from relatives included, "My relative is always treated with dignity and respect, I am impressed with all of the staff," "Staff are respectful when talking to my relative, they are dealt with patiently and not hurried in any way," and, "They are treated with respect all the time. The staff never enter a room without knocking first." All care records containing people's confidential information were stored securely.

During our inspection we made observations during lunch. Most people ate in the main dining room and there was a menu on display. Tables were nicely laid with pink table cloths. People who used wheelchairs were sat on chairs and not left in wheel chairs to eat their meal. There were two choices of main meal and the food was nicely presented. Food taken from the kitchen to the dining room was covered by a lid.

Lunch was a sociable occasion and people were chatting with one another or staff members. Some people were being assisted with eating. This was done in a patient manner and the staff member chatted and interacted with the person throughout the meal. Staff also communicated well with people eating independently, for example, by asking them if they wanted anything else or if they had enjoyed their meal. We observed a TV in the corner that was turned on and quite loud, there was nobody watching it and it was

an unnecessary distraction. We spoke with staff about this who turned it off. Staff did not remove plates unless they asked people's permission and had asked if they had finished.

Some of the care records we looked at provided information on the most effective ways for staff to communicate with people, for example, 'prefers to be told information in the morning when most alert', 'staff to speak slowly'. One person had a unique type of hearing aid and there was guidance in the care plan for staff about what it was and how it worked.

One person living at the service reverted to using their native spoken language at times. Although they were able to speak and understand English, a member of staff who spoke the same language communicated with the person, this helped to make the person feel more relaxed. Staff had also devised pictorial flash cards with common words of the language and the English equivalent so that staff were able to communicate with the person more effectively.

People told us the service had an open visiting policy so that relatives and friends could visit at any time. All relatives we spoke with told us they were always offered refreshments and were always warmly welcomed when they entered the service. One relative told us, "The staff all make me feel very welcome, they all greet me by my name which is nice." The service had a friends and relatives room with a kitchenette where people could meet with their visitors in a private and quiet environment. Friends and relatives were also able to stay overnight to support their relative if required.

For people who had no family or friends to speak on their behalf, the service had details of an advocacy service. An advocacy service helps to ensure that the views and wishes of the person are heard.

At the time of the inspection, the service did not identify anybody with any specific diversity and cultural needs although staff did support people with specialised diets and forms of communication such as non-English and non-verbal. We asked staff what equality and dignity meant to them, one told us, "It means treating people the same but remembering that each person is different."

Is the service responsive?

Our findings

We looked at the care records for eight people and found that care plans did not always contain current and consistent information about people's healthcare needs and requirements. For instance, one person's nutritional risk assessment showed they were at risk of choking due to swallowing difficulties, nursing staff had made a referral to SALT for advice. Whilst the written advice from the visiting professional was within the person's care records, advice had not always been incorporated within the plans of care. This meant that the main care plan had not been updated by staff to reflect the current needs of the person in relation to this area.

Another care file we looked at recorded that a person had been losing weight and so had been referred to the dietician, the person was then supported with a fortified diet by staff. However, we again noted that the main care plan had not been amended to reflect this need and there was no guidance for staff to follow as to what a fortified diet was. We spoke to the registered manager about this who confirmed that the person was receiving the correct diet.

Another care file we looked at showed conflicting information about the person's mobility status. Part of the care records recorded that the person was mobile with assistance and was at a high risk of falls whilst another part of the records showed that the person used a hoist and sling to mobilise. We spoke to the registered manager about this, they confirmed that the person did require a hoist and sling and would ensure that care records for all people would be amended to reflect consistent information and that care plans would be updated.

At the time of our inspection, the service was in the process of changing the paperwork to people's care records and so some of the care records we looked at had yet to be updated. Shortly after our inspection, the registered manager confirmed that care plans had been amended to ensure the advice of professionals had been incorporated and that people's care records now contained consistent information throughout.

In some care records we looked at 'My Life so Far' documents were in place. These were one-page profiles and provided information about the person such as the name they liked to be called, their former occupation and the people who were most important to them. These documents helped staff get to know the people they cared for and provide care based on people's individual likes and dislikes. It was evident from some care records that people's relatives had been involved in providing this information. A member of staff told us, "We ask people's families about their background, so we know about them and what they are like as a person."

Care records were maintained by staff who reviewed each person's care daily. Appropriate risk assessments were in place and reviewed regularly. Some of the relatives we spoke with were involved in decisions about the relative's care. One relative told us, "I have had a meeting with the GP and the nurse from the home today. They reviewed my relative's medication and spoke of the way forward."

During our inspection, we observed that the service met people's particular needs. This helped to ensure the

service protected people's rights under the Equality Act 2010. For example, by communicating with people in their native language and supporting people with the use of hearing and visual aids. People told us that they could have access to a minister if required. A chaplain visited the service once per week to provide Holy Communion for anyone who wanted it.

During our inspection we observed periods of time when people were sat in the lounges with either TV or music on in the background. Whilst people had a choice in what they wanted to watch or listen to, during these times there was little engagement with members of staff.

The service employed an activity co-ordinator who worked at the home Monday to Friday and were employed to develop and facilitate a range of activities. However, they had been unavailable since May 2018 and so the service had recently employed a second activity co-ordinator who was due to commence employment the following week. One person told us, "I take part in activities when they are on but at the moment there's not much going on." Activities usually on offer included sing along, memory box, bingo, arts and crafts, jigsaws. At the end of every month the service would hold an end of month party. The registered manager told us about their plans to create a dedicated room for activities to take place. People also enjoyed activities provided by external providers, such as poetry reading, hair and beauty treatments and pet therapy, activities were available on almost a daily basis.

People had access to a complaints procedure and people we spoke with knew how to make a complaint. The manager maintained a record of any complaints received and the actions taken to resolve them. All of the relatives we spoke with told us they would raise concerns without hesitation if they had anything to say.

We looked at processes in place to gather feedback from people and listen to their views and saw that the manager sought feedback from both people using the service and their relatives. Feedback included quality assurance surveys in the form of questionnaires and both resident's and relative's meetings. Questionnaires were in pictorial format to help people living at the service understand the questions easier. They were kept in the reception area of the service and so were easily accessible. All of the relatives we spoke with were aware that questionnaires were available in reception.

Questionnaires include topic areas such as food, cleanliness, laundry, activities and friendliness and helpfulness of staff. Records showed that regular meetings took place with people living in the home and their relatives. All relatives we spoke with who had attended the relative's meetings felt they were useful. One relative told us, "I attend the relatives' meetings and always feel that people are listened to."

We noticed that there was not a formal way of gathering feedback from visiting healthcare professionals. We discussed this with the registered manager. By the second day of our inspection the registered manager had devised a survey to give to any healthcare professionals visiting the service.

At the time of the inspection, there was nobody receiving End of Life Care. We noted that people's end of life wishes were not recorded in their care files. We spoke to the registered manager about this who informed us that they generally liaised with relatives regarding this but would make a record of people's wishes if they felt comfortable to discuss it.

Is the service well-led?

Our findings

During our inspection we looked at how the registered manager and provider ensured the quality and safety of the service. We saw that audits were in place with regards to the safety of the environment, fire safety, infection control, care plans, accidents and incidents and medication. The provider employed a quality assurance manager who visited the service monthly to undertake audits.

Although registered provider audits had been completed, we found that they did not always identify areas where improvements were required. This meant that systems in place to monitor the quality of the service were not always effective.

Medication audits had not identified our concerns in relation to the recording of the use of thickener in fluids, and care plans audits had not highlighted inconsistent recording of information in people's care records and insufficient information contained in people's PEEPs. In addition, environmental audits had not identified issues with the cleanliness of the service and the need to make the environment more suited to the needs of people living with dementia.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent some time talking to the registered manager. They told us they had recently recruited a clinical lead who was shortly due to start at the service on a full time basis. Part of the clinical lead's role would be to oversee matters such as care plans and medication administration.

The registered manager had joined the service a month prior to the inspection. We saw that positive changes had been made since our last inspection and the service was making progression towards improvement.

People's feedback about the management of the service was very positive. People we spoke with told us the registered manager was open, transparent and approachable and they felt able to raise any issues or concerns with them. A member of staff told us, "There have been improvements here from the day they started," another told us, "They are so supportive, interested in what's going on, they just make things easier."

Relatives we spoke with also spoke positively about the registered manager, comments included, "I have seen an improvement since they have taken over as manager, there are improvements in the home and the staff seem more upbeat," "Since the manager has been here things are very positive, they are obviously working on feedback they have been given. The staff are more responsive, more professional and engaging. More staff have been recruited. If I mention anything to them [the registered manager] they take it on-board straight away."

The registered manager had a clear vision on what improvements they wanted to make to enhance the

quality of life for people living at the service. They had already implemented the installation of a wet room. This was based on people's feedback that they wanted a separate showering facility. The registered manager told us about their plans to refurbish the décor and make the environment more suited to the needs of people living with dementia. For example, by painting people's bedroom doors a different colour to help people with orientation. They also planned to redesign communal corridors to make them appear like outside areas with pictures and murals on the walls designed to mimic windows leading to a 'view' of the 'outdoors.'

There were regular staff meetings which enabled staff to share their views and opinions. We looked at a selection of minutes of meetings which showed topics discussed included training, safeguarding, accidents and incidents, complaints and compliments. It was evident that best practice was promoted during these meetings and staff were encouraged to develop the service further, for example, by learning lessons from things that had gone wrong in the past.

There was a wide range of policies and procedures in place to guide staff in their roles. Topics included safeguarding, equality and diversity, infection control, whistleblowing, dignity and privacy, medication and end of life care. Staff we spoke with were aware of the home's whistleblowing policy and told us that they would not hesitate to raise any issues they had. Having a whistleblowing policy helps to promote an open and transparent culture within the service.

The registered manager had notified CQC of any events that had occurred in the home in accordance with our registration requirements. This meant that CQC were able to monitor information and risks regarding the service.

Ratings from the last inspection were displayed within the home as required. The providers website also reflected the current rating for the service. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Audit processes did not always identify concerns relating to information contained within care records and the suitability and cleanliness of the environment. This meant the risk to people was not always monitored and mitigated.</p>