Aarondale Health Care Limited

Aarondale House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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 took place on 30 June and 1 July 2016 and was unannounced. At our last inspection on 27 August 2014, we followed up concerns regarding the quality assurance system for the service and found it to be compliant at that time.

Aarondale House is a care home that is located in the resort of Hornsea about half a mile from the seafront. It has single and shared accommodation for a maximum of 20 people with needs relating to old age and dementia.

The registered provider is required to have a registered manager in post and on the day of the inspection, there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

The homes manager was able to demonstrate they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, we found that Mental Capacity Act (2005) guidelines were not always followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that although staff had received an induction and completed training in a variety of topics, they had not completed training that would enable them to safely carry out physical restraint. Staff told us they felt well supported; however, the supervision records we saw showed that staff were not receiving regular supervision. This was a breach Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that robust quality assurance systems were not currently in place and therefore issues of concern in relation to care plans, staff supervisions, activities and staff training had gone undetected. We observed that some record keeping within the service required improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not informed the CQC of all significant events. This meant we could not check that appropriate action had been taken to help prevent reoccurrence and address the concerns. This was a breach of Regulation 18 of the (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

People were offered some activities to be involved in. However, there was no formal programme of activities in place and the people who used the service we spoke with told us they would like the opportunity to be involved in more activities. We made a recommendation about this in the report.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported. However, we found some elements of the care plans required further development.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were appropriately actioned; however, they were not always effectively recorded.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's assessed needs. Staff had been employed following appropriate recruitment and selection processes and we found that the recording and administration of medicines was being managed appropriately in the service.

We found assessments of risk had been completed for each person and plans had been put in place to minimise risk. The home was clean, tidy and free from odour and effective cleaning schedules were in place.

People's nutritional needs were met. Most people told us they enjoyed the food and that they had enough to eat and drink. We saw people were offered a choice of food and drink and were provided with refreshments throughout the day.

People told us they were well cared for and we saw people were supported to maintain good health and had access to services from healthcare professionals. We found that staff were knowledgeable about the people they cared for and saw they interacted positively with people living in the home. People were able to make choices and decisions regarding their care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff displayed a good understanding of the different types of abuse and had received training on how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to provide care to people.
Risk assessments were in place and reviewed regularly, which meant they reflected the needs of people living in the home.

The home had a robust system in place for ordering, administering, storing and disposing of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

We found that although staff had completed training in a variety of topics, however they had not completed training in safe and effective physical intervention.

The homes manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, we found the Mental Capacity Act (2005) guidelines had not been followed.

People's health needs were met. People who used the service had access to additional treatment from healthcare professionals, when needed.

People had access to adequate food and drinks and information was available to meet any specific dietary needs.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and dignity, had their independence promoted and were provided with a choice about how their care was delivered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. However, these plans were not always reflective of people's current needs.

There was no formal programme of activities in place and people told us they would like the opportunity to be involved in more activities.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had a quality monitoring system in place; however, it was not effective and failed to identify areas of concern. Record keeping within the service needed to improve.

The CQC had not been notified of all significant events that occurred at the service. This meant we could not check that appropriate action had been taken.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

Aarondale House

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 registered 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 30 June and 1 July 2016 and was unannounced. One adult social care (ASC) inspector carried out this inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events, or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we spoke with four members of staff, the registered manager, the proprietor, four people who used the service, one healthcare professional and three people's relatives. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, medication records for six people, handover records, supervision and training records for three members of staff and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

People who used the service were protected from abuse and avoidable harm by staff who had completed relevant training and knew how to keep people safe. Staff we spoke with demonstrated a good knowledge of safeguarding people and could identify the types and signs of abuse, as well as knowing what to do if they had any concerns. One member of staff said, "I've never seen anything of concern whilst I've worked here. If I did I would go straight to the senior or the manager."

The home had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered provider used the local authorities safeguarding tool to ensure any incidents, accidents or allegations of abuse were appropriately reported and investigated. This was confirmed from safeguarding records and concerns we looked at. We saw these were usually well recorded and submitted to both the local safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents. However, when we viewed the services accident and incident file we found that a number of incidents in relation to physical confrontations between people who used the service had not been reported to the safeguarding team and no notification had been received by the CQC. We saw that one person had suffered a fractured hip following a fall but this had not been reported to the CQC. This was addressed in the 'well led' section of this report.

We saw the service had systems in place to ensure that risks to people and the environment were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included an assessment of risk for falls, eating and drinking, continence, moving and handling, pressure care, challenging behaviour and medication. Risk assessments were reviewed on a regular basis and amended accordingly. We saw Personal Emergency Evacuation Plans (PEEP) were in place for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We saw there were nurse call bells in all bedrooms and people had a portable 'lifeline' fobs so they were able to summon assistance if needed. This showed the registered manager had taken steps to reduce the level of risk people were exposed to.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas safety, fire extinguishers, emergency lighting, passenger lift, nurse call system and all lifting equipment including hoists. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all pre-employment checks had been completed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed

to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with terms and conditions of employment and information regarding the purpose of their position and a description of their duties. This helped to ensure staff knew what was expected of them.

We spoke with the registered manager about how they ensured there were enough staff on duty to meet the needs of the people using the service. They told us that they had a settled staff group who were aware of the needs of the people who used the service. They said that the number of staff rostered on duty was usually enough to meet the day to day needs of people using the service. They explained that if the staff required additional support then they were available to help and as the domestic staff had received all necessary training, they were also able to provide support.

One person using the service told us they were concerned that during the night there were only two staff on duty. They told us, "If there was an emergency and two staff had to deal with it, who would look after the rest of us?" We discussed this with the registered manager who explained that during the night, they were on call and as they lived in close proximity to the service they could be on site in a matter of minutes should this be required.

On the day of the inspection the staff on duty included the registered manager, one senior carer, two care staff, a domestic worker, a handyperson, the cook and a kitchen assistant. A member of staff told us, "We can be busy in the morning, but we manage to get everything done that we need to." They said, "Once people are up and dressed and have had breakfast we usually have chance to stop and chat with the residents, ask how they are and see if there is anything they need" and, "Every day is different, some days you have time, other days you don't." We found there was sufficient numbers of staff to safely care for people living in the home.

Checks of the training records showed us that all staff who administered medication in the home had received appropriate training. In addition to the medication training, staff were required to undertake four competency checks before they were able to administer medication to people using the service. The service used a monitored dosage system (MDS) supplied by a local pharmacy. An MDS is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken and when.

We observed medication being administered at different times throughout the day and saw that this was carried out in an unobtrusive and respectful manner. We looked at how medicines were managed within the home, carried out stock checks and checked a selection of medication administration records (MARs). We saw that medicines were obtained in a timely way so that people did not run out of them, stored securely, administered on time, recorded correctly and disposed of appropriately. Regular medication audits were completed and this ensured any errors were identified at the earliest opportunity. One person using the service told us, "I always get my medication on time, no issues there."

We found the service to be clean, tidy and free from odour. Regular deep cleaning was undertaken by the services domestic staff and we saw that there was detailed information available for staff on hand washing and what to do in the event of an outbreak or suspected outbreak of an infectious disease within the home.

Requires Improvement

Is the service effective?

Our findings

We looked at the induction and training files of staff to check that their induction would give them the necessary skills and knowledge to care for people who lived at the home. We saw that newly recruited members of staff were required to complete an induction covering home specific topics that focussed on elements such as the homes fire procedure and the action staff should take in the event of an emergency. New staff were also required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives and covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity and infection control. Following the completion of the Care Certificate, staff were enrolled on the National Vocational Qualification (NVQ) level 2 in care. NVQs are now known as Quality Credit Framework (QCF) or diplomas and are nationally recognised work based training courses. Training records we viewed confirmed 86% of staff currently held NVQ qualifications in health and social care.

However, we saw that one member of staff who had started working in the home in November 2015 had only completed training in fire awareness, health and safety and moving and handling. This meant that important training including safeguarding had not yet been completed. We discussed this with registered manager and they told us that they would address this immediately and ensure that all essential training was brought up to date.

We viewed training records and saw that staff completed a variety of training in topics including, safeguarding, moving and handling, fire awareness, health and safety, infection control, equality and diversity and dementia awareness. This was delivered through a distance learning programme and via face-to-face training delivered by external training providers for topics such as moving and handling and first aid. We were also told that staff were given the opportunity to shadow more experienced staff members before they were included on the rota. This was confirmed by the staff we spoke with, one told us, "I got a workbook for each part of the training; you have to complete a test at the end and then it gets sent off for certification. You can keep the workbook which is useful to refer to" and, "I completed three twelve hour shifts shadowing before I was put on the rota." This meant that staff were given the skills and knowledge required to support them in their roles.

We saw that staff had completed training in challenging behaviour and this taught them useful techniques to enable them to distract and de-escalate people who displayed distressed or anxious behaviour. However, this training did not provide them with the necessary skills and knowledge to physically restrain people. Staff at the service were currently using low level holds to enable personal care to be given to one person using the service; this meant they did not have the skills to complete all aspects of their role. We addressed this with the registered manager who booked the entire staff team on to a non-violent crisis intervention (NVCI) training course during our inspection. We saw this was scheduled to take place on 19 July 2016.

Staff told us they were well supported by senior staff and the registered manager. One said, "The seniors are a big help, they always point me in the right direction, the manager is just great." Another said, "Yes, I have supervision with the manager or the seniors; we discuss if I have any concerns and it gives me an

opportunity to raise any issues." We looked at supervision records and saw that the frequency that staff received supervision was inconsistent. Some staff had received supervision in February 2016; however, we saw that the last recorded supervision for others was January 2015. We discussed this with the registered manager and they told us that due to the recent uncertainty surrounding the future of the home, supervision had not been completed as frequently as they had intended.

This was a breach of Regulation 18 (1) (2) (a) Staffing of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty 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 Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection, there were three DoLS authorisations in place and the service was waiting for assessments and approval for six more applications they had submitted.

We saw that the service was following MCA guidelines in some instances but not others. For example, we saw that one person had their medication administered covertly. Covert administration of medication is the administration of medication to people in a disguised format without their knowledge or consent. For example it can be hidden in food or in a drink. We saw that a best interest meeting had taken place and there were clear instructions in place regarding how this should be administered.

However, we also found examples where the MCA guidelines were not being followed. One person using the service had a risk assessment in place for their 'challenging behaviour'. This included information regarding the extent of the risk, the type of behaviour displayed, the triggers or circumstances for the behaviour and how staff should respond to reduce or eliminate the risk. Following conversations with staff and the registered manager it was apparent that although the risk assessment advised staff to use 'gentle persuasion' and 'leave [Name of person] and just keep going back until they calm down', staff were actually using low level physical restraint to enable them to complete personal care tasks. We saw the person's family had agreed to this intervention to ensure the person received the necessary personal care, however, there was no plan in place for staff to follow, staff had not completed the necessary training to intervene in this way and no best interest meeting had taken place. Best interest meetings are held when people do not have capacity to make important decisions. Health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. This showed that the homes registered manager and staff had not followed guidelines as set out in the MCA 2005.

This was a breach of Regulation 11(1) (2) (3) Need for consent of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some staff had completed training on MCA and DoLS and during our discussions with staff; we found they had appropriate levels of knowledge regarding MCA for their roles. Staff were able to explain how they gained people's consent to receive the care provided. One member of staff said, "It's all about talking to people. I make sure they know what I am about to do and ask them if it's ok before I start." Another said,

"Some people can't communicate verbally, so I look at their body language for signs that they are happy or not."

The registered manager told us that all of the food was prepared on the premises and different weekly menus were rotated to provide different meals on a four-week cycle. We observed the breakfast, lunch and tea time meals and saw people were supported by staff who offered encouragement, prompts and physical assistance ensuring that they received enough to eat. When people required assistance or prompting to eat their meals, staff sat with them and encouraged them to take an adequate diet. People had access to a range of adapted utensils and plate guards in order to help them eat their food independently. We saw that people were offered a second helping of both their main meal and dessert. People were given adequate time to eat their meals and were asked whether they had finished eating before their plates were removed.

Most people who used the service enjoyed the food. One person told us, "The food is gorgeous, absolutely gorgeous." Another said, "The food is great." However, one person told us, "The fish is terrible" and, "I asked for my meal without peas and I still got them. I hate peas." We saw there was one choice of hot meal at lunchtime and people could request an alternative if they wanted. One person said, "It's fish today, I don't like fish so I'll have a sandwich instead." Another told us, "We get a choice at breakfast time but I've not been asked what I want for my lunch." We discussed this with the register manager who told us that staff asked people what they wanted in the morning and provided the cook with a list so they knew if people wanted an alternative meal. We saw a copy of the list in the kitchen and this documented people's food preferences and whether they had any allergies or special dietary requirements.

We saw that the provision of food was discussed by people at the last residents meetings and they were able to make suggestions regarding what food they enjoyed or what food they would like to see included on the menu. However, as this was poorly recorded and we were unable to determine whether the suggestions made had in anyway influenced the meals that appeared on the menu.

We saw that people's nutritional needs were assessed and plans were put in place to ensure they were met. People were weighed on a regular basis and we saw that in general people using the service recorded monthly weight gains. Some people in the home had food and fluid charts in place to record their daily intake. We found that these accurately recorded the type and quantity of food and fluids consumed by the person. One relative we spoke with told us, "[Name of person] is doing great, they have put on a stone and a half, and they are now eating really well." Periods of weight loss were accounted for and we saw that people had been referred to the GP or the Dietician for a full nutritional assessment when appropriate. For example, following a fall, one person using the service had fractured their hip. A referral had been made to the GP and dietary supplements had been prescribed.

We saw that the kitchen had cleaning schedules in place and that the temperature of fridges and food was taken daily. The home had achieved a rating of 5 (very good) following a food hygiene inspection undertaken by the Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen.

Peoples health needs were supported and were kept under review. We saw evidence that individuals had access to their GP's, district nurses, chiropodist, opticians and dentist. Where necessary, people had also been referred to the relevant healthcare professional. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). One person who used the service said, "If I need my GP then they call them, all I have to do is ask." A relative told us, "[Name of person] had a bed sore and was unwell at the time. It would have been much easier for the staff just to leave him in bed, but they were really positive and got him up and into the day room." They told us, "It's all cleared up

now, but could have got worse if the staff hadn't followed such a positive regime." This showed the registered manager took appropriate steps to ensure people's health needs were being met.

Good

Is the service caring?

Our findings

All of the people we spoke with told us staff were kind, caring and knowledgeable about their needs. Comments included, "The staff are nice, they are all very good", "The staff are really friendly and very caring", "I have no complaints, the staff will help you all they can, I get on with them all" and, "Some of the carers are very good, better than some of the others."

People told us they were given a choice about how their care was provided. They told us they were able to choose what time they got up in the morning and what time they went to bed. They told us they were given a choice of where they sat and whom they spent their time with. However, one person told us they would like more choice regarding their lunchtime meal. Staff told us they try to provide people with choices whenever they can. One member of staff said, "We try and give people as much choice as possible. In the morning they can get up when they want to, if they want a lie in they can have it and we come back when they are ready" and, "I offer a choice of what clothing people want to wear, I hold different items up until they are happy with the selection."

Staff knew the people they supported and were knowledgeable about their needs. We saw that one person using the service was carrying a doll and staff found this helped ease the person's anxiety. Staff used the doll as a guide to how the person was feeling and whether they would cooperate with them. One member of staff said, "When we go to see whether [Name of person] is ready to get washed and dressed for the day I ask if I can hold their doll, if they give me it then I know that they are feeling ok and will let us help them, if they do not give me the doll I know it is better if I come back later and try again." They continued, "This helps us make sure we are not causing [person] any unnecessary distress." A visiting relative told us, "The staff show consideration to all residents and know how to respond to people" and, "The staff are really very fond of those who can be a bit challenging; they know when to give people space and let their mood subside and when they need to intervene."

People told us they were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bathroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified situation. They also ensured that they did not provide any care considered personal in the communal areas of the home. One person who used the service said, "Yes, they treat us with respect; I would tell them if they didn't." A member of staff said, "We always knock on doors before entering and when I am supporting people in the toilet or bathroom, I always make sure the door is locked behind us."

We observed staff supporting a person to move from their dining chair into their wheelchair. We saw staff showed patience as they encouraged the person do as much of the transfer themselves, advising them to use their legs, whilst maintaining their safety. Staff talked them through the process explaining where they were positioned and what they needed to do next to complete the manoeuvre. This showed the staff understood that people needed to continue to attempt to do things for themselves to enable them to maintain their independence.

We observed that people's friends and relatives were free to visit people living in the home whenever they wanted and that these visits took place both during the day and in the evening. On the day of this inspection, we saw that one person's husband had come to spend the day with them. The home had provided them with a meal and they sat together in the dining room. We saw that people who lived in the home were able to choose where and with whom they spent their time. This enabled people to develop friendships with people who had similar interests. One person told us, "I've made friends we all look out for each other."

The registered manager told us they had developed links with local voluntary and professional advocacy services. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. At the time of this inspection, one person who used the service was utilising an advocacy service.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

We saw that pre-admission assessments had been completed by the registered manager prior to people moving to live in the home on either a permanent or a temporary basis. This ensured that the home was able to meet the needs of the person and assessed any impact their arrival could have on staffing levels. One relative we spoke with told us, "The pre-admission assessment was very thorough; we were involved throughout."

An assessment was undertaken which identified people's support needs and care plans were then developed outlining how these needs were to be met. Risk assessments were also developed for those aspects of care where potential risk was identified. The care plans we viewed were written in a person centred way and contained information including the person's life history, one page profiles, daily routines and likes and dislikes. This information enabled staff to develop a better understanding of the person they were supporting and informed the way they responded to different behaviours.

Care plans addressed any identified need including, personal care, eating and drinking, well-being, continence, medication, moving and handling, social interactions, relationships, contacts and finances. We saw that care plans were well written and described in detail how to meet each person's different needs. However, we found that some elements of the care plan did not fully reflect people's current needs. For example, one person experienced periods of distress, which caused them to display both verbal and physical behaviour that could challenge the service. Despite thorough incident reporting we found that there was no plan in place to advise staff how to effectively support the person during these periods of distress. We also found that staff were using low-level holds to restrain another person and despite this, there was no clear plan in place to indicate how this intervention should be carried out.

We found that there was a lack of accurate care records in place and have reported on this further in the well-led section of this report.

The service had a complaints procedure in place and this was displayed in the entrance to the home for visitors and people using the service to see. The registered manager told us they received very few complaints and had not received any formal complaints since the last time we inspected in September 2014. They referred to minor issues as 'niggles' and explained how they dealt with these quickly to prevent any concerns / issues from escalating.

People who used the service and their relatives knew how to make a complaint. One relative told us, "If I have any issues I tell the staff and they communicate that back to the manager." We saw that the manager listened to people's concerns and took action, for example, one person had stated they were unhappy that other people using the service could enter their room. The manager had arranged for a lock to be fitted to their door to ensure the person was kept safe and felt reassured. Another person who used the service mentioned that some clothing had gone missing whilst it had been laundered. This had also been addressed during a recent night staff meeting and staff had been given instructions to prevent this from happening. However, we found that neither issue had been recorded in the complaints file. It is important

that all complaints, concerns and compliments be accurately recorded to enable recurring issues to be dealt with at the earliest opportunity.

Other opportunities were available for people to offer feedback on the service they were receiving. Annual surveys were distributed to people who used the service and meetings for people using the service took place. We viewed the notes from the last meeting held in April 2016. Different topics were discussed, including menus, activities and laundry. However, the recording of the meetings did not provide sufficient detail to enable any constructive follow up. We also noted that that these meetings were only held on an annual basis. We addressed this in the well-led section of this report.

We were told that people using the service had access to some activities and these were provided by staff. A member of staff said, "There is always something going on. We have entertainers coming in, some people like to play board games like snakes and ladders, some like doing crosswords and other like listening to music, reading or watching TV." Another said, "The ladies mainly like one to one time." One person who used the service told us, "I like to do crosswords, quizzes and also help the staff out by setting the tables."

However, we found there was no formal programme of activities in place and all of the people who used the service we spoke with told us they would like the opportunity to be involved in more activities. One person who used the service told us, "I would like to get out more often, but I have to have somebody with me. It's driving me crackers." Another said, "We don't have much to do. We used to have movement to music coming in every month and now they've cut it right down." A visiting relative told us, "I think there could possibly be more activities, staff do stop and sit with people and residents do get to go out and they will sit out at the front to get some fresh air; I understand it is logistically difficult."

We discussed with the registered manager and the staff team. They told us that activities were offered, but people generally refused to be involved. A member of staff told us, "We have an activity book and fill it in to say whether people have participated or not but a lot of people refuse as they like to watch TV or read a book." They said, "We used to have music for health visiting, however people got a bit bored of that." Another said, "I would like to see residents get out more, but most of the time they don't want to." The registered manager explained how they had arranged a trip to the theatre, telling us, "We arranged to go and watch Annie at the theatre, we had 16 people booked on but in the end only six wanted to go; we ended up ringing other care homes to see if anybody wanted to go."

We saw the registered manager had taken some steps to try to capture people's views in relation to activities through service user surveys and meetings. We viewed the minutes of the most recent meeting and saw that although trips out of the home were discussed, there was no agreed date or destination for the trip arranged during this consultation. We also saw no discussion was recorded in relation to activities within the service. Through our observations, we noted one person who was living with a dementia related condition spent long periods scratching at the arm of the chair in which they were seated. We saw that although the person did at times use a therapy doll, they did not have access to any additional sensory or tactile equipment such as 'twiddle muffs' or 'sensory cushions'.

We recommend the service seek advice and guidance from a reputable source on the delivery of an activity programme.

Requires Improvement

Is the service well-led?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services and it is a requirement of the registered manager to ensure that the CQC is notified of all DoLS authorisations. Prior to the inspection, we had checked and found that no notifications had been received from the home in relation to DoLS authorisations. We also found the home had not notified the CQC of a significant injury sustained by one of the people using the service and notifications had not been submitted following several incidents between people using the service.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had not informed the CQC of all significant events. This meant we could not check that appropriate action had been taken.

This was a breach of Regulation 18. Notification of other incidents, of The (Registration) Regulations 2009.

We saw that a quality assurance system had been developed and this included audit checks, meetings, stakeholder surveys and the analysis of the information collated from these. However, we found that the system was not always effective as issues of concern in relation to care plans, staff supervisions, activities and staff training had gone undetected.

The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of the regulations and we saw that they were appropriately maintained, up to date and securely held. This meant that people's personal and private information remained confidential.

However, some record keeping within the service needed to improve. We found that the information collated from service user surveys and meetings lacked information on any agreed actions or items to follow up and people's complaints were not recorded in the complaints file.

We also found that care plans were not always reflective of people's current needs. This meant that staff did not have access to accurate records in respect of each person using the service, which potentially put people at risk of harm.

This was a breach of Regulation 17 (2) (a) (b) (c) Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection; this meant the registered provider was meeting the conditions of their registration and that there was a level of consistency for people using the service and for staff.

The staff we spoke with told us they felt well supported and that they could approach the manager with any issues or concerns. One told us, "The manager is great. If I ever have a problem they are very easy to talk

with." Another said, "Yeah, the manager is reasonable; I can discuss any issues." Visitors to the service said, "The manager was really very supportive to us during a period of disruption and they ensure [Name of person] gets all the treatment they need by working with different community based health professionals." Another said, "The manager is great, very proactive with things, nothing is too much trouble, they are really very good." One person who used the service told us, "We don't always see the manager, but when we do they are always very nice."

The registered manager was able to communicate with the staff team in a number of ways. This included staff meetings, the handover logs, and by posting staff briefings in the memo file and on the notice board in the shift office. Relatives we spoke with told us they were pleased with the frequency of communication with the service. One person said, "We have good communication with the home, we speak with them on the phone or they come and give us an update when we visit."

The registered manager had developed positive relationships with the community health teams, the local GP practice and the pharmacy. A visiting health and social care professional told us, "The manager will request support when needed and they also acknowledge when a person's needs are too high for the home. "

We saw that the registered manager had distributed quality assurance surveys to people who used the service and these had been completed either by themselves or a member of their family. Feedback was generally positive with comments including, 'I have nothing to complain about, the service and care are very good', I am very happy with the level of care [Name of person] receives and so are they, they love it here' and, 'Care needs for dad have increased recently and they have been fully met by staff.' However, where negative feedback was received, we saw this had not been followed up. For example, one person's relative stated, '[Name of person] enjoys the musical activities, more of these would be nice.' We saw no evidence that this comment had been responded to or whether musical activities had increased. The registered manager assured us that comments of this nature would be followed up in the future.

We discussed the culture of the service. The registered manager told us, "We are a small, homely and friendly home and we have a low turnover of staff, which means the staff know the residents very well." They said, "I have an open door policy and residents, relatives and staff can come and speak to me about anything, as I also work alongside the care staff at times, this enables me to speak with the residents on a daily basis; it keeps me in the loop."

We saw that the service had a mission statement in place that outlined the registered providers aims and objectives. We saw the aim of the service was to 'provide the highest quality care to our residents at all times, by making them feel safe, secure and cared for.' They aimed to achieve this 'through continually looking for and implementing ways to improve'. It stated the services objectives as, 'Improving people's quality of life, ensuring people were treated with dignity and respect and all residents are treated equally.' We were told that staff were provided with a copy of the mission statement so they were clear on the register provider's vision for the service.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service were not protected against the risks associated with receiving care and treatment they had not consented to or which had not been agreed in a best interest forum. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service were not protected from the risks associated with receiving care from staff who were not properly trained to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)