

Ablecare (Torquay) Limited

Greycliffe Manor

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Greycliffe Manor is a care home which provides accommodation and personal care for up to 25 people living with dementia and other physical health needs. People who live at the home receive nursing care from the local community health teams.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection took place on 24 May and 1 June 2016 and the first day was unannounced. On the first day of our inspection there were 21 people living in Greycliffe Manor and on the second day of our inspection there were 22. People had a range of needs, with some people being more independent and others requiring more support with their mobility and care needs. A large number of people who lived in Greycliffe Manor were living with dementia.

During our inspection we found some risks to people were not being well managed. Some risks relating to people's behaviours had not been identified and steps had not been taken to manage or mitigate these risks. Where one person had lost a significant amount of weight over several months, the registered manager had failed to identify the actions being taken by staff were not having the desired effect. Although the person was not putting on weight or maintaining their weight, further input had not been sought and new monitoring practices had not been implemented.

Guidance available for staff on the administration of 'when required' medicines was not always available and we found records relating to medicines were not well maintained. We have made a recommendation the provider seek guidance relating to the management of 'when required' medicines and maintaining medicine records.

Most people who lived in Greycliffe Manor were living with a form of dementia which could have affected their ability to consent to care or make specific decisions at specific times. The registered manager did not have clear knowledge of the Mental Capacity Act 2005 (MCA) and none of the people who lived in the home had had their mental capacity assessed. No best interest decisions had been made. This meant some people may not have had their consent obtained in ways which adhered with the MCA.

During our inspection we saw staff involving people in their care, asking them for their opinions and offering them choices. Staff did not have clear understanding of the MCA or DoLS but they did demonstrate the principles of the MCA during their interactions with people. The registered manager had recently become registered in February 2016 and had booked themselves onto training courses to learn more about the MCA and DoLS. These training courses were taking place around two weeks after our inspection. The registered manager told us they had been waiting to clearly understand these areas before completing mental

capacity assessments and DoLS applications where required. Following our inspection the registered manager has been completing this work and seeking advice from professionals.

Where some people had individual needs relating to their behaviours and emotional wellbeing, staff did not always have the guidance required, or support people in ways that met these needs.

The systems and processes in place at the home to monitor the safety and quality of care had failed to identify the concerns we found during our inspection. Where issues had been identified the provider had failed to create action plans to respond to these issues. People's records had not been maintained in a way which ensured they were accurate and contained up to date information.

People and relatives were complimentary about the care provided at the home, the competence and kindness of the staff and the leadership of the registered manager. We observed people's needs being responded to by caring and attentive staff who valued people's dignity. Staff had worked hard to ensure people were happy and their well-being was maintained.

People felt safe at the home and staff had received training in safeguarding people and knew how to raise concerns if they were worried about anybody being harmed or neglected. Contact numbers and safeguarding procedures were on display for people and staff to use should they have any concerns. People and relatives felt the management at the home would respond quickly and effectively to any concerns.

People were provided with activities that met their social needs. People took part in music events, walks in the garden or around the local area, crafts, baking and exercises. People enjoyed the activities and on the first day of our inspection people took part in a singalong with the activities coordinator. We saw staff spending individual time with people and supporting them at their own pace. There were enough staff to see to people's needs and sit and talk with people individually in an unhurried manner.

There were robust recruitment processes in place to ensure that suitable staff were employed. Staff performance was monitored with supervisions and spot check observations to ensure any poor practice was picked up and acted upon.

The food at Greycliffe Manor was of good quality and appetising. People enjoyed their meals in a social way where chatter and laughter was encouraged. People were provided with food that met their personal preferences and tastes and were always offered second helpings to ensure they had eaten enough to meet their appetites. Where people required support with eating or needed their food prepared in a specific way, such as pureed, this was offered in an appetising and personalised way.

The home was open, welcoming and friendly. Some building and decorating work was taking place in order to improve the environment, particularly for people with dementia. A new quiet lounge had been created and a passenger lift had been installed for people's convenience.

There was clear leadership at the home and the people who lived in Greycliffe Manor knew who the registered manager was and felt comfortable approaching them. The registered manager felt supported by the area manager and the directors and the staff felt supported by the registered manager. People's opinions were sought through the means of meetings and surveys in order to improve on the home and the quality of the care provided. Between our first day of inspection and our second, the registered manager and the area manager had actively responded to some of the concerns we had raised in order to minimise risks for people and improve.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not always being protected from harm and people's records not always being accurate or up to date. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not safe.

Some risks to people were not always identified and acted on.

Some medicine records were not well maintained and there was a lack of guidance around 'when required' medicines.

People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns.

People were supported by sufficient numbers of staff to meet their needs.

There were arrangements in place for foreseeable emergencies.

Is the service effective?

Requires Improvement ●

The service was not effective.

Neither the registered manager nor the staff had clear understanding of the Mental Capacity Act 2005 and no mental capacity assessments had been completed.

The registered manager did not have a clear understanding of the Deprivation of Liberty Safeguards.

Staff had completed training to give them the skills they needed to meet people's individual care needs.

People were supported to have enough to eat and drink. People were supported to eat in a personalised way which met their needs and preferences.

Is the service caring?

Good ●

The service was caring.

Staff displayed caring attitudes towards people and we observed positive and respectful interactions between people and staff.

Staff supported people at their own pace and in an

individualised way.

Staff knew people's histories, their preferences, likes and dislikes.

People were treated with dignity and respect.

Is the service responsive?

The service was not responsive.

There were not always plans to manage people's individual behavioural needs as well as their emotional needs. Staff did not always have the information they needed to support people in a way that met their needs.

People benefited from meaningful activities which reflected their interests.

Staff knew people well and encouraged people to remain as independent as possible.

People felt comfortable making complaints and were encouraged to do so.

Requires Improvement 

Is the service well-led?

The service was not well led.

The systems the provider had in place to assess and monitor the quality and safety of care had not identified the concerns we found during our inspection.

Audits and checks had been completed without action plans being created to respond to issues identified.

People's records did not contain up to date and accurate information.

There was a clear management structure in place that staff felt supported by.

The provider sought feedback from people, relatives and staff in order to improve the service.

Requires Improvement 

Greycliffe Manor

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 was 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 visit took place on 24 May and 1 June 2016 and was unannounced on the first day. The inspection was carried out by two adult social care inspectors on the 24 May and one adult social care inspector on 1 June 2016. Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us.

Some people who lived in Greycliffe Manor were able to talk to us about their experience of the home but some were less able to do so because of their dementia. Therefore, as well as speaking with people, we conducted a short observational framework for inspection (SOFI). This framework consists of observations of life at the home in order to help understand the experiences of people when they are not able to communicate with us.

We looked around the home, spent time with people in the lounges and dining room and observed how staff interacted with people throughout the days. We spent time with people over the lunchtime meal on both days of inspection. We spoke with five people who lived in Greycliffe Manor, one relative of a person who lived at the home, three members of staff, one senior manager, a director and the registered manager. We looked at the way in which medicines were recorded, stored and administered to people. We sought feedback from external healthcare professionals who had visited the home and received a response from one of them.

We looked in detail at the care provided to five people, including looking at their care files and other records. We looked at the recruitment and training files for three staff members and other records in relation to the operation of the home such as risk assessments, policies and procedures.

Is the service safe?

Our findings

People's risks were generally well managed. However, where one person was displaying behaviours which could put themselves or others at risk of harm, these had not been fully assessed or responded to. Staff did not have clear guidance to follow on how to minimise the risks of this person harming themselves or others. Staff had not sought guidance from professionals on how to manage this person's behaviours and no risk assessment had been created.

Where one person had been losing weight over several months, staff had not assessed whether the management plans they had in place to increase this person's weight were working or whether other actions should be taken. There was no evidence this person had been referred to a specialist and there was no evidence they had put on any weight or remained at a stable weight since July 2015. Staff were not monitoring this person's food intake and had not increased the monitoring of their weight. This meant this person was at risk of continuing to lose weight.

This was a breach of regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people who lived in Greycliffe Manor required support from staff to take their medicines. We found where medicines had been prescribed to be administered 'when required' there were not always clear guidelines as to when the medicines should be administered. For example, one person was prescribed medicine to be taken when they became distressed. There was no indication of how staff would recognise when the person was beginning to become distressed, or if alternative interventions should be used before the medicine was given. Without clear guidelines there was a possibility staff may interpret signs of distress differently and therefore administer medicines before trying alternative strategies. One member of staff told us they had clear understanding of when these medicines should be used but the provider could not ensure themselves all staff had the same understanding.

Some of the records relating to people's medicine administration records (MAR) and medicated creams were incomplete. The registered manager and staff assured us people were having their medicines and their creams as prescribed by their doctor. Following the first day of our inspection the registered manager conducted a full audit of medicines management at the home and by the second day a lot of work had gone in to ensure people's medicine records were reviewed.

We recommend the provider seek some guidance from a reputable source in relation to the management of 'when required' medicines and maintaining medicine records.

People told us they felt living in the home and had confidence in the staff. People's comments included "Do I feel safe? Perfectly. They care for me very very well here" and "Oh yes I feel safe". One person's relative said "Feel she's safe. Excellent home I feel".

People were protected by staff who knew how to recognise signs of possible abuse. Staff told us they had received training in how to recognise harm or abuse and knew where to access information if they needed it. They told us they would initially tell the registered manager if they had any concerns but also knew how to escalate concerns outside the home. The home's safeguarding alert protocols were displayed on the staff notice board along with emergency contact numbers and safeguarding contact numbers for staff to use.

Medicines were stored safely and securely. The home used a monitored dosage system where medicines were pre-packed each month by the local pharmacy. This system was designed to minimise the risks associated with medicine administration. We observed staff administering medicines over the lunchtime period on the two days of inspection. People were told about their medicines and were asked if they wanted to take them. People were approached by staff and asked whether they wanted any pain relief. Staff made sure people had a drink to hand before giving them their medicines and waiting for them to take them before leaving.

There were enough staff at the home to care for people in the way they needed. People and relatives spoke highly of the staff. There were four care staff on duty from 8am until 8pm, and two staff were awake during the night from 8pm to 8am. On the first day of inspection there were four care staff on duty, the registered manager, the deputy manager, two cleaners and two kitchen staff. Throughout the inspection we saw people's needs being met in a timely manner. We did not hear call bells ringing for a long time before being answered. We saw staff regularly going into people's rooms to check that they were alright and didn't need anything. Staff were quick to respond to people's needs and requests.

Recruitment practices ensured, as far as possible, that only suitable staff were employed at the home. Staff files showed the relevant checks had been completed to ensure staff employed were suitable to work with vulnerable people. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained, this protected people from the risks associated with employing unsuitable staff.

Greycliffe Manor provided support and accommodation to people who had varying levels of needs relating to their health, mobility and dementia. Most risks to people's safety, health and well-being had been individually assessed and responded to. For example, where one person was at risk of falls, staff had sought guidance from professionals and had put measures in place to minimise the risks of this person falling or injuring themselves if they did fall. During our inspection we observed staff supporting people to mobilise and reposition safely and in line with best practice guidance.

Where accidents and incidents had occurred, the registered manager had reviewed these to ensure the risks to people were minimised. Staff recorded incidents in an accident book which was kept up to date. Details of the incident as well as actions taken following the incident were recorded. A falls register was created and updated for each person which detailed the circumstances of the fall and the actions taken. The registered manager reviewed these in order to identify potential patterns and to minimise the risks of reoccurrence.

The premises and equipment were maintained to ensure people were kept safe. For example, fire alarms, electrical installation and bath temperature checks were completed regularly. There were infection control measures in place to protect people and people and relatives commented on the cleanliness of the environment. Comments included "It's always clean. I never smell anything when I come in" and "It's always clean". The home had received a rating of five in relation to food hygiene where food was the highest rating.

There were arrangements in place to deal with foreseeable emergencies. For example, each person had a personal emergency evacuation plan that told staff how to safely assist them in the event of a fire. These

plans were reviewed every two months by the registered manager in order to ensure they were up to date.

Is the service effective?

Our findings

Most people living in Greycliffe Manor were living with a form of dementia and this may have affected their ability to make specific decisions at specific times. This could also have affected their ability to be able to consent to living in the home and receiving care. We therefore checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

None of the people who lived in Greycliffe Manor had had a mental capacity assessment. The registered manager had taken on their position and registered with the Care Quality Commission (CQC) in February 2016. They told us they did not have a clear understanding of the MCA and were due to attend a training course in the next two weeks. They told us no mental capacity assessments had been completed prior to them taking on their position and they had postponed completing any until after their training course. Best interest decisions had not taken place where they may be required. For example, one person had bed rails in place on their bed in order to minimise the risks of them falling out. This measure was a restriction for this person but there was no consent obtained from them. No best interest decision meeting had taken place in order to agree this decision was appropriate. Staff told us they had recently received MCA training, but could not really remember much about it. They told us it related to people having choice but they did not know anything about best interest decisions. The provider was therefore unable to assure themselves people's consent was obtained in ways which adhered to the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). If a person is under continuous supervision, is not free to leave on their own and does not have the mental capacity to consent to these arrangements, they are being deprived of their liberty. An application must be made to the local authority for legal authorisation. Greycliffe Manor had locked doors which required a code to be opened. The registered manager told us they did not give this code to people but that staff would take people out if they wanted to leave the home.

Some people who lived in Greycliffe Manor were under constant staff supervision and were deprived of their liberty to leave the home on their own. This meant DoLS applications may have been required for these people. The registered manager told us they did not have any knowledge about DoLS and were awaiting their MCA training and specialist DoLS training which was due in the next two weeks before completing any application forms. This meant it was possible people may have been unlawfully deprived of their liberty at the time of our inspection and in the months prior to this. The registered manager told us all measures in place were the least restrictive options for people as far as they knew and therefore these missing applications and legal authorisations had not had a detrimental effect on people.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities)

Although the registered manager and staff did not have effective knowledge about the MCA, we saw staff always sought consent from people before carrying out care or supporting them in any way. Staff respected people's rights to make decisions as far as they possibly could and we saw people being asked for their opinions and choices in ways they could understand. For example, some people were shown options of foods and drinks to choose from as well as being given the options verbally. This helped people make decisions where they could.

Where people had specific needs relating to the consistency of their food and their fluid levels this was sometimes confusing. For example, staff told us one person had difficulties with swallowing their food and they were on a pureed diet to stop them from choking. During our inspection we saw this person eating a piece of cake which was not in a pureed form. We looked at this person's care plan which said they were on a pureed diet because they had difficulties with chewing but did not have difficulties with swallowing and could eat sandwiches. One person's fluids were being monitored as part of a plan to minimise the risks to their skin. These were being monitored on charts but there was no space on the monitoring charts for the fluid to be totalled. This meant there was no way for staff or the registered manager to ascertain whether this person had drunk enough each day. We found this person's skin was in good condition however and there were no concerns about their fluid intake. We spoke with one person's relative who spoke highly of the food and the ways in which their loved one was supported to eat. They said "They puree all her diet into individual portions". They told us they helped their loved one eat and did this in a kind, respectful and relaxed way.

During our inspection we observed the lunchtime meal on both days. A cook worked 8am to 8pm every day and care staff did no food preparation. The cook told us there were no restrictions on the food budget and people's choices and preferences were sought. They told us they created the food menus based on what people liked. The food looked appetising and people and relatives spoke highly of it. Comments included "The food is very nicely done", "The food is nice" and "The food is good". People were given options and alternatives if they did not like the meal on offer but everyone spoke highly of the meals they had on both days of our inspection. Snacks and drinks were available throughout the day to meet people's needs. For example, one person told staff they were hungry in the late morning and the cook prepared a cheese sandwich for them which they enjoyed. Staff ensured people had eaten enough food to satisfy them by offering second helpings of the meal. A member of staff came by to show people the options of seconds available so they could choose.

The lunchtime meal was served either in the dining room, in the lounges or in people's rooms, depending on their preferences. The dining room was pleasant with vases of flowers on every table. On the second day of our inspection there was soft, classical music playing during the meal and people enjoyed a glass of sherry. The lunchtime experience was sociable with people and staff chatting and laughing amongst themselves. Where one person chose to eat in the quiet lounge, staff has respected this and their meal was brought to them on a tray with a lid on top of the plate in order to keep it warm.

Where people had specific needs associated with eating these were responded to. For instance, people had specific plates, bowls and cutlery in order to help them eat independently. People were encouraged to eat on their own where they could but others were supported. Where people required encouragement we saw staff took it in turns to get down to the person's level and encourage them to eat their meal. They offered them alternatives and assisted them with cutting their meal into smaller portions.

Staff were knowledgeable about people's care needs and benefitted from training and support which helped them meet the needs of each person. People and relatives told us they had confidence in the staff and that they care for people well. Comments included "They're very good. The staff are very very good here", "It's not an easy job but they do it well", "The staff definitely know what they're doing" and "All the carers are very good. They seem to know what they're doing".

Staff were able to describe people's needs, personalities and preferences in a way which showed they had good knowledge about individuals. Staff received regular training in topics such as dementia, moving and handling, infection control and the mental capacity act 2005. Our observations showed staff cared for people well and demonstrated they had the skills to support people in the way they needed. Staff received regular supervision and annual appraisals.

The environment at the home was in the process of being renovated and adapted to best support people living with mobility problems and dementia. Recent improvements which had been made included a passenger lift being installed to help people move between floors. A partition had been made to separate the lounge into two rooms, one quiet lounge and one general lounge where activities took place. Other work was taking place in relation to the décor and the general environment in order to deal with required improvements. There were various items available for people to pick up and handle throughout the home and we saw people making use of this. This helped provide stimulation for people living with dementia stimulation. There were also magazines, books and current newspapers available for people to read within the lounges.

People saw healthcare professionals promptly if they needed to do so. Care files contained records of referrals to a range of healthcare professionals including GPs, community nurses, occupational therapists, mental health assessors, speech and language therapists and chiropodists.

Is the service caring?

Our findings

People and relatives spoke highly of the staff and their caring attitudes. Comments included "They are very kind and very nice", "They are wonderful, very caring", "They devised a whole scheme of caring" and "They're all very nice up here".

The atmosphere in the home was warm and welcoming and we saw plenty of pleasant conversations, laughter and warmth between people and staff. The home was decorated in way that felt homely in every room. There were pictures on the walls and homely decorations. Relatives told us they were free to come to the home at any time and were made to feel welcome.

We observed staff being caring towards people and treating them with dignity. For example, we saw a member of staff asking a person if they wanted to use the bathroom. They did this by getting down to their level and whispering in their ear in order to maintain their dignity. They supported this person to the bathroom discreetly without drawing attention to the situation. This demonstrated the respect this member of staff had for this person.

People were supported in an unrushed and pleasant manner by staff who knew them well. Staff knew people's preferences, their likes and dislikes. For example, staff knew people's food preferences. On the second day of inspection the lunchtime meal consisted of a turkey dinner with all the trimmings. Staff knew one person did not like gravy so they did not put any on their plate but still asked them whether on this occasion they may want some.

Staff displayed their caring attitudes towards people in other ways. For example, a member of staff had recognised one person had a large number of photographs which they loved looking at. The staff member had organised the purchase of some photo albums and was now supporting the person to organise their photos. The staff member had recognised the importance of the photos as a prompt to discussing the person's past life and people and events that were important to them. A member of night staff had brought in their sewing machine on occasion in order to take in people's clothes for them so they fit in ways which were more flattering. This displayed kindness and staff going above and beyond their job role for the well-being of the people they supported. Staff told us they care about the people who they supported and said "The residents make it all worthwhile".

People's dignity and privacy were respected at all times. For example, staff knocked on people's doors and waited for a response before entering. People received personal care in private and staff did not discuss people in front of others. People looked clean and their clothes were neat and reflected their preferences. One person's care plan stated they liked to have their handbag with them at all times. We saw this person had their handbag with them and when they went to the dining room for their lunch, staff brought the person's handbag with them so they wouldn't miss it.

Where people had difficulties relating to their dementia, staff treated people with dignity and never spoke down to them. One relative said "They always talk to her as a person". We saw staff speaking with people at

their own pace and encouraging and supporting people to express themselves and move about the home freely.

People and their relatives were consulted and involved in decisions about their care but often this was not recorded. There was evidence people's likes, dislikes, preferences and routines were included in their care plans. Staff were able to tell us about people from having spoken with them and their families.

The activity coordinator told us how people living in the home cared for each other. They told us one person had a love for dogs, so during one afternoon activity people had created hanging mobiles of dogs and put photos of dogs on this person's wall to make them smile. This had brought happiness to this person.

Is the service responsive?

Our findings

People's emotional needs had not always been met. Where people had specific needs relating to their behaviours staff had not assessed, planned for or effectively managed these. For example, one person displayed behaviours which caused themselves and others emotional distress. No specific guidance had been created for staff to refer to in order to provide this person and others with the reassurance they required during these times, or information on how to minimise the risks of these incidents occurring. Professional guidance had not been sought in relation to this issue and there was no process to ensure staff responded to this person in a consistent way. Staff were unable to tell us how they identified triggers for this person's behaviour and told us they did not have specific guidance to follow to manage and minimise this behaviour. The individual emotional needs of this person had not been assessed, planned for or met.

This was a breach of Regulation 9 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they did not regularly read people's care plans and one member of staff told us they had never seen a care plan. They told us they knew how to care for people and about changes to people's needs through daily handovers. There was effective communication between staff members during handovers and during day to day working which had ensured staff knew people's care needs. We fed this information back to the registered manager as we had concerns new staff or agency staff would not have access to this information if they were to start work. Between our first and second day of inspection the registered manager had introduced a sheet for staff to sign once they had read people's care plans and a place for staff to sign when they had read care plan reviews. They told us they would ensure staff read people's care plans regularly in order to ensure they were working with up to date information.

People were encouraged to remain as independent as possible. People's care plans stressed what they were able to do for themselves and how staff were to support that. Staff demonstrated they encouraged people's independence in their practice. During our inspection we saw staff encouraging one person to get out of a chair on their own and praise them for their mobility and strength. One person said "I prefer my independence so they help me with that".

The home had a complaints policy in place which people could access. There was information about the Care Quality Commission and how people could contact us if they wanted to in large print in the entrance hallway. People were encouraged to make complaints if they wanted to and felt comfortable doing so. Comments from people included "I can't see anything that I would complain about but I wouldn't feel uncomfortable complaining at all". People knew who the registered manager was and felt they could approach them with complaints if they had any. One person saw the registered manager whilst we were speaking with them about complaints and they said "If we've any complaints we come to you", speaking to the registered manager. The registered manager told us no complaints had been received at the home in the recent months. Relatives told us they felt comfortable raising any concerns they had with the registered manager and felt confident these would be listened to and acted on. They said about the registered manager and the deputy manager: "They are both very approachable. Definitely they would do something

about it. They're very quick if they have any concern. They are on the ball if there's anything wrong".

People had access to a range of activities that met their social care needs. An activity coordinator worked at the home and organised afternoon activity sessions for people to participate in. Activities included animal handling, cookery, music, singalong, art, reminiscing, quizzes, ball games and exercises. The activity coordinator knew people's likes and dislikes well. On the first day of our inspection a musical entertainment session took place. People were encouraged to sing and the activity coordinator knew each person's favourite song. They said "We personalise what people like. It's very rewarding. There's something every day". They gave us examples of activities they had organised and how people had enjoyed them. People had clearly enjoyed the singing on the first day of our inspection and had been encouraged to join in. Where people had chosen not to join in, the activity coordinator had spent some individual time with them either in their room or in the quiet lounge. An entertainment book was kept which recorded the activities that had taken place, who had joined in and people's feedback about the activities.

Where the activities coordinator had spent individual time with people in their rooms they had recorded what they had discussed and what topics of conversation the person had enjoyed. This helped to ensure the activities available at the home reflected people's preferences. People told us they enjoyed the time they spent at the home. Comments included "When it's a nice day we go out in the garden. It's a lovely garden. I went out in the garden yesterday" and "They keep us busy. We go out for walks". On the second day of our inspection a number of people went out for a walk with a member of staff. During both days we saw staff spending time with people, sitting and talking with them and going into people's bedrooms to interact with them and avoid them feeling lonely.

Is the service well-led?

Our findings

The systems and processes at the home to monitor the safety and quality of care had not been effective in identifying the concerns we found during our inspection. Although there were processes in place to audit medicines, these audits had not identified the lack of guidance around 'when required' medicines and issues relating to the recording of medicines. The registered manager and senior staff had regularly reviewed people's care plans and risk assessments but had failed to identify that some risks to people had not been assessed or acted on, leaving people at potential risk of harm.

A number of different checks and audits had been carried out by the registered manager, the area manager and a director. The registered manager conducted a monthly audit check and the most recent one had looked at medicines, laundry, people's weights and night staff induction and training. There was no evidence an analysis had been done on the findings of these checks. There were no action plans or comments on the findings of these audits therefore this had not been effective in identifying any areas for improvement or concerns and had not been effective in taking action to improve safety and quality. The area manager conducted weekly audits and checks and the director also regularly came to the home and conducted checks. These checks did not produce recorded action plans for the registered manager to work through and therefore there was no way of ensuring any improvements were being made. The registered manager told us they did not regularly create or work off action plans and instead used "mouth to mouth communication as opposed to action plans". They told us they had made improvements following individual issues identified but were unable to demonstrate these or give us examples.

People's records were not always accurate or up to date and therefore the provider was unable to assure themselves people were receiving the care they required. For example, people's repositioning charts and observation charts contained a large number of gaps and information within people's care plans was at times contradictory and confusing.

Each person's care plan was checked once a month and the registered manager told us these were updated to reflect people's changing needs. But we found some care plans contained contradictory information about people. For example, one person's care plan stated they used a zimmer frame to mobilise as they were at high risk of falls, however further on in their care plan it stated they mobilised independently. During our inspection we saw this person mobilised with a frame and staff were encouraging them to use it correctly.

This was a breach of regulation 17 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The leadership at the home was clear and people and relatives had confidence in that leadership. People spoke highly of the registered manager and felt they were approachable. Staff told us they felt supported by the management and enjoyed working at the home. The registered manager told us they felt supported by the provider and the senior management and could always go to them with any questions or concerns. During our second day of inspection we saw the area manager had been working with the registered

manager to tackle some of our concerns and provide them with support. Staff had clear roles with clear responsibilities and there was either a senior member of staff or a member of the management team on call every night and weekend in order to provide support if needed.

There was an open culture in the home which was led by the registered manager. The registered manager sought people's views as well as staff views and the views of relatives in order to improve the service. Regular 'staff meetings' and 'resident meetings' took place in order to seek feedback from people and staff. During resident meetings people were asked about the meals, the cleanliness of the home, the care they received and the activities provided. We looked at the minutes from the most recent meeting and saw a number of people had raised concerns about the behaviours of a particular person disturbing them. There was no action plan or record of how this feedback had been dealt with. The registered manager told us they had responded to these by creating the partition between the lounges in order to create the quiet lounge for people. They said ""Since the residents meeting there is now the quiet lounge".

People were asked for their feedback informally following meals, activities and during general conversations. But they were also asked for their feedback in formal ways in the form of satisfaction surveys. We looked at the results of the most recent survey dated March 2016 and saw comments from people including "Staff go out of their way" and "Food is very good". Relatives were also asked for their feedback in the form of surveys. One relative we spoke with said "I have been asked for feedback. I have had three surveys in the last two years".

The home had notified the Care Quality Commission of all significant events which had occurred in line with their legal obligations.

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 9 HSCA RA Regulations 2014 Person-centred care Service users did not always receive care which met their individual needs. Regulation 9 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always obtained in accordance with the Mental Capacity Act 2005. Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to service users had not always been assessed and action was not always taken to mitigate these risks. Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess and monitor the quality and safety of care were not effective and records were not well maintained. Regulation 17 (1)(2)(a)(b)(c)

