Elmbank Residential Care Home Limited

Elmbank Residential Care Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection that took place on 21 July 2015.

Elmbank Residential Care Home is owned by Elmbank Residential Care Home Limited and is registered to provide accommodation with care for up to 14 people. At the time of our visit, there were 11 older people living at the service. The majority of the people who live at the home are living with dementia, some have complex needs. The accommodation is provided over two floors that were accessible by stairs and a lift.

Elmbank did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Medicines were administered by staff in a safe manner, however arrangements for the recording and storage of controlled drugs was not in accordance with current legislation. The medicines administration records were accurate and contained no gaps or errors. However, information about the quantity of each medicine in stock had not been completed and there was no sample of staff's initials on file. There were no written individual PRN [medicines to be taken as required] protocols in place for each medicine that people took. Any changes to people's medicines were prescribed by the person's GP.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at identifying and correcting poor practice.

The majority of the people living at the home are living with various forms of dementia. Some people were unable to communicate with us verbally, but others told us they felt safe. One person told us, "I feel very safe here, the staff are lovely." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from abuse. There were arrangements in place to record and store people's money in a safe way.

People's care needs including risks were recorded in their care plan. The manager told us that he was in the process of changing the care planning format that was in place at the home. We were shown the new format and found that this did not contain risk assessments for people's identified needs. People whose care needs were recorded using the old style care planning format did include risk assessments for identified needs. Staff that we spoke with were able to explain safe procedures that they would follow to minimise any risk.

Recruitment practices were safe, were followed and relevant checks had been completed before staff commenced work. People who lived at the home and staff told us that there were enough staff on duty to support people at the times they wanted or needed. The home had a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed.

Staff had a clear understanding of what to do in the event of an emergency which would affect the home such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used.

Staff told us they had received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) but their explanations about these areas were limited. The manager understood their role and responsibilities with regards to the Mental Capacity Act and Deprivation of Liberty Safeguards. We found that not everyone had a DoLS application completed (at present six had been completed) and submitted to the local authority in accordance with legislation. The manager told us that he would review and complete the remaining applications. We made a recommendation that the provider complete and submit the necessary DoLS applications in accordance with current legislation.

People had enough to eat and drink throughout the day and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of people's health. The service worked effectively with health care professionals and referred people for treatment when necessary.

It was not easy for people living with dementia or who had impaired sight to find their rooms or their way around the service as all areas looked the same. Sections of the service were not easily identifiable; walls and doors were painted the same colour. People's bedrooms were personalised with pictures, photographs or items of personal interest. However we saw no evidence of anyone's individual or personal interests integrated into the home outside of their rooms. We made a recommendation for the provider to research and implement ways on how to make the environment 'dementia friendly'.

Staff treated people with kindness and respect. Positive caring relationships had been developed between people and staff. Staff showed kindness to people and interacted

Summary of findings

with them in a positive and proactive way. Staff were caring. People told us that staff treated them with respect and dignity when providing personal care. People felt that staff knew them well. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

People said that staff were attentive and responsive to their needs. People's needs were assessed when they entered the service and reviewed regularly. Care records were updated by staff involved in their care. People had access to equipment to assist with their care and support to enable them to be independent.

There was no physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided them with something to do during the day when organised activities were not happening. The manager acknowledged that further work was needed to ensure people received stimulation and enjoyable activities. We made a recommendation that the provider reviews activities in accordance with people's hobbies and interests

The provider had sought, encouraged and supported people's involvement in the improvement of the service. People's opinions had been recorded but no information regarding action taken had been captured.

People told us if they had any issues they would speak to the manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

People told us the staff were friendly, supportive and management were visible and approachable.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not consistently safe.

Medicines were administered by staff in a safe manner, however the recording and storage of controlled drugs was not in accordance with current legislation.

People were safe as systems and procedures were in place to protect them from harm. They felt safe with the people that provided their care.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were safeguarding procedures in place to help protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Staff had limited working knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. We found that not everyone who required it, had a Deprivation of Liberty application completed and submitted to the local authority in accordance with legislation.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff provided care and support which promoted well-being. Healthcare professionals were involved when assessing health risks.

People were supported to have access to healthcare services.

Is the service caring?

Good 

People said that staff were kind and treated with them with respect.

Positive caring relationships had been developed between people and staff.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring.

People told us that staff treated them with respect and dignity when providing personal care.

People felt that staff knew them well and supported them to make choices to help maintain their independence.

People's relatives and friends were able to visit.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Summary of findings

The activities that were provided did not always stimulate people living with dementia or complex needs.

People said that staff were attentive and responsive to people needs.

People's needs were assessed when they entered the service and reviewed regularly. Care records were updated by staff involved in their care.

People were provided with the necessary equipment to assist with their care and support to enable them to be independent.

People told us they knew what to do if they needed to make a complaint. People were encouraged to voice their concerns or complaints about the service and they were dealt with promptly.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The provider had systems in place to regularly assess and monitor the quality of the service provided. These were not robust or effective enough to identify, correct poor practice and improve the service provided.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. People's opinions had been recorded but no information regarding action taken had been captured.

People told us the staff were friendly, supportive and management were visible and approachable.

Elmbank Residential Care Home

Detailed findings

Background to this inspection

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

We visited the service on 21 July 2015 and it was an unannounced inspection. The inspection was conducted by two inspectors.

During the visit we spoke with five people who use the service. We also spoke with two care staff, the cook and the manager. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff. We looked at two bedrooms with the agreement of the relevant people. We reviewed a variety of documents which included three people's care plans, risk assessments, medicines administration records and accident and incident records. We also reviewed minutes of meetings, complaints records and some policies and procedures in relation to the quality of the service provided.

On this occasion we had not asked the provider to complete 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 improvements they plan to make. This was because we were responding to some concerns we had received.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We contacted the local authority and health authority, who had funding responsibility for people using the service.

We last carried out a follow up inspection in September 2014 and found no concerns.

Requires improvement

Is the service safe?

Our findings

We checked the arrangements for the storage and recording of medicines. We found that medicines were stored securely and in appropriate conditions. We checked medicines records and found that a medicines profile had been completed for each person and any allergies to medicines recorded. However the records did not contain a photograph of the person to whom they related which could be used as identification to ensure the correct person was receiving their medicines. The medicines administration records we checked were accurate and contained no gaps or errors. However, information about the quantity of each medicine in stock had not been completed and there was no sample of staff's initials on file to provide information about who completed the record.

There were no written individual PRN [medicines to be taken as required] protocols in place for each medicine that people took. This should provide information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. These procedures should help ensure people receive their medicines in a consistent way.

The storage and recording of controlled drugs were not in accordance with National Institute for Health and Care Excellence (NICE) guidelines. The drugs were stored in a locked cabinet but there were also other, inappropriate items stored alongside the medicines There was an error recorded in the controlled drugs book. We found an entry recorded on 19/7/2015 stated X tablets remained, when it should have been Y. When we counted the medicines there was in fact Z, indicating that one tablet was missing. When we asked the manager to explain the errors, they stated that they would conduct an investigation. After the inspection we received information from the manager regarding the investigation which was due to staff error, appropriate action has been taken to rectify the problem.

Medicines policies and procedures were in place to guide and inform staff. These included policies on covert medicines this is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication; as and when required medicines (PRN), controlled drugs and medicines errors.

Failure to have effective systems in place to store and manage medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of the people living at the home were living with various forms of dementia. Some people were unable to communicate with us verbally, but others told us they felt safe. One person told us, "I find it fine here. We are treated well. They look after us." We observed that people looked at ease with the staff that were caring for them.

Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to safeguarding. One told us, "I would go to a senior or the manager and report it. If I was not listened to I would go to the owner." Another told us, "We have to maintain their safety and inform the manager very fast if concerned. Must go higher if needed." Staff were able to describe the different types of abuse and what might indicate that abuse was taking place.

The service did not have a copy of the most recent local authority safeguarding policy or the company policy on safeguarding adults so staff may not be fully aware of the most up to date information about what to do in the event of suspected or actual abuse.

There was a staff recruitment and selection policy in place and this had been followed, to ensure that people were supported by staff who were suitable. Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provided proof of identification and contact details for references. The provider ensured that the relevant checks were carried out to ensure staff were suitable to work at the service. Staff confirmed they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff also confirmed that they attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

The manager told us that there were usually two care staff on duty at all times but that, "One of the ladies (staff) cancelled today so only me and X on the floor." People who lived at the home and staff told us that there were enough staff on duty to support people at the times they wanted or needed support. One member of staff told us, "We usually have two staff in the morning. The situation today is rare.

Requires improvement

Is the service safe?

We also have two carers on during the afternoon and night. This is usually enough to meet people's needs." Another member of staff said, "I think we have enough staff. If we work as a team with colleagues its ok."

During our inspection we observed that staff were available when people needed assistance with personal care. The home had a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed. When this was activated we observed that staff responded promptly. In addition to the manager and care staff a cook and domestic staff member were allocated on shift seven days a week.

The manager told us that staffing levels were decided by the provider "After I have passed information to her." The manager was not aware of a formal assessment tool that was used to decide safe staffing levels. The manager was able to give an example of when additional staff were allocated during the night when the needs of a person who used to live at the home had increased. They also informed us that the home was in the process of advertising for an activity person and that this person would increase the numbers of staff deployed on shift and would benefit people who lived at the home.

The manager told us that he was in the process of changing the care planning format that was in place at the home. We were shown the new format and found that this did not contain risk assessments for people's identified needs. Many of the care plans contained information how to manage risks despite the lack of formal risk assessment. One person's mobility care plan stated 'Can transfer from wheelchair but mostly may require assistance from two staff. No falls in the last month although history in past. Full hoist is in place and to be used if X feels tired and their mood is low. Assess each time before transferring and to monitor them when the hoist is in use to make sure they are steady and in no immediate danger'. People whose care needs were recorded using the old style care planning format did include risk assessments for identified needs. These included assessments for moving and handling, behaviour, pressure areas, falls and nutrition. Staff were knowledgeable about people's needs, and what techniques to use to when people were distressed or at risk of harm. This meant that people were supported by staff who understood their needs.

Staff that we spoke with were able to explain safe procedures that should be followed if someone sustained an injury or had an accident. One person told us, "If they are on the floor we put them in safe position but do not move them. Call ambulance." Another told us, "If someone has a fall always get advice. Check they are ok. We are not a nursing home so must get medical advice. If needed call 999."

If needed, the home held small amounts of money on behalf of people. There were arrangements in place for storing and recording this. This included individual records, receipts for items purchased on people's behalf and limited access by people who worked at the home. We did find three minor discrepancies in the amounts held and the corresponding records held. The manager explained that this was in place when they took up post and said that they would amend the records accordingly.

We saw instructions displayed in the home about how to evacuate the building in the event of emergency. We did not see in people's care plan a 'Personal Emergency Evacuation Plan. (PEEP) ' The manager confirmed they did not have PEEP in place for people. This meant that staff did not have information on how to support individual people in the event of an evacuation.

There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used. This minimised the impact to people if emergencies took place.

Requires improvement

Is the service effective?

Our findings

Staff told us they had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards but their explanations about these areas were limited. One member of staff told us, "For their safety we take some small freedoms such as front door locked to keep them safe." The manager understood their role and responsibilities with regards to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. DoLS provide a legal framework to prevent unlawful deprivation and restrictions of liberty. They protect people in care homes and hospitals who lack capacity to consent to care or treatment and need such restrictions to protect them from harm. We found that not everyone had a DoLS application completed and submitted to the local authority in accordance with legislation. The manager told us they had submitted six applications to date, as they had been reviewing each person's needs and applying one by one, hence the delay. They told us they would review people's needs and submit the necessary documentation.

We recommend that the provider complete and submit the necessary DoLS applications to the local authority in accordance with current legislation.

People told us that their health and care needs were met. One person said, "I have a nice little bedroom of my own. I can go up there if I want or down here. I'm happy."

We observed that staff checked with people that they were happy with the support provided and gained their consent. Staff sought people's agreement before supporting them and then waited for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

People's care plans contained consent forms for the use of their photograph and for staff to administer medicines. These had been signed by the person. They also had a communication care plan that reinforced to staff the person's communication methods or needs. This stated for example that 'X is able to communicate their needs and is mentally alert. X is able to understand while being spoken to provided it is written down for them afterwards.' This person also had a mental capacity care plan that confirmed the person had capacity to make decisions but at times required support and encouragement. This stated 'Try to help X to make decisions in best of interest for himself when and if required and to respect his decisions'. The person's ability to consent was also reinforced in a Do Not Attempt Cardio-Pulmonary resuscitation form which they had signed. This meant that staff knew how to communicate with people to ascertain their consent before proceeding with support tasks.

We also reviewed a person's mental health assessment that rated their mental condition, social behaviour, memory loss, likelihood to wander and depression. The assessment did not state if the person lacked capacity to make particular decisions. The same person had consent forms for use of their photograph, weight being taken and medicines being administered by staff that had been signed by a relative. They also had a Do Not Attempt Cardio-Pulmonary resuscitation form that had been signed by a doctor. This stated that the person lacked capacity to consent and that the decision to withhold resuscitation had been discussed with a relative. The manager told us that everyone's care plans were being reviewed.

People told us about the food at the home. Comments included, "Lunch was very nice, "Don't know what's in the sandwich but it's very nice" and "lunch was lovely."

We observed the lunchtime experience. The majority of people had their lunch in the dining room. A member of staff was present during the lunchtime period who offered assistance to people when needed. They did this with consideration and sensitivity. They sat next to people who they assisted, and supported people at their individual pace whilst offering words of encouragement. People appeared to enjoy the meal and staff were observed offering and giving seconds to people. The mood throughout lunch was relaxed and friendly and people were enjoying the food and each other's company.

The cook was able to explain to us the individual preferences of people and information was in place about people's specific nutritional needs. They told us, "The manager tells me people's dietary requirements. We have

Requires improvement

Is the service effective?

two people who are diabetics. Also one person on a pureed diet and two others on a soft diet. We also have two other people who sometimes have a soft diet depending on their mood." People's nutritional needs were recorded in care plans which included their likes, dislikes and preferences. For example one person's nutritional care plan stated 'Enjoys his meals and drinks and loves his cups of coffee and cornflakes at breakfast along with a couple of slices of toast. Weight has remained almost steady during the last month. Able to use normal cutlery by self but at times may require assistance to slice his meat.' Another person who was living with dementia had a care plan that informed staff 'Tea with one sugar. Food, try two or three times and say well done when she takes it, talk softly.' This meant that people were support by staff who knew their nutritional and dietary needs.

A pictorial menu was displayed in the dining room that helped people who were living with dementia to understand the meal choices available to them. This informed people that there was a choice of breakfasts and evening meals. Lunch options were not included in the pictorial menu; staff told us that they discussed the menu with residents, so they could choose what they would like to eat. People were offered a choice of drinks and snacks at other times during the day to ensure they kept hydrated.

There were qualified, skilled and experienced staff to support people living at the home. The manager ensured staff had the skills and experience which were necessary to carry out their roles. Staff told us they received training and support that enabled them to care for people effectively. One told us, "I have done food hygiene, fire and infection control. I'm in the process of completing dementia training and will be doing first aid training in August." Another member of staff told us, "I have done dementia training, also moving and handling, fire and safeguarding." This meant that people were supported by staff who had the necessary skills and training to support their needs.

Staff told us they had regular meetings with their line manager to discuss their work and performance. One member of staff told us, "We have staff meetings and I had a supervisory meeting with the manager about a month ago." Another told us, "We have meetings. The last one was about a month ago. Sometimes these are as a group and some are one to one. We talk about the residents to make sure they are happy." Staff files included records of supervision and appraisal taken place. This meant that staff had the opportunity to discuss their role and any areas of concern with their manager.

People had access to healthcare professional such as doctors, district nurses, chiropodists, opticians, dentists and other health and social care professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in the care records. People's weight was monitored and appropriate action taken when issues were identified. For example one person had lost weight over a period of six months, food charts were in place and the GP prescribed supplements. As a result their weight stabilised and their wellbeing improved. This showed the management and staff ensured people's health needs were met.

It was not easy for people living with dementia or who had impaired sight to find their rooms or their way around the service as all areas looked the same. Sections of the service were not easily identifiable; walls and doors were painted the same colour. Although there were signs on the doors describing rooms there were no visual aids to help people. People who were living with dementia may need help with finding and recognising their bedrooms. An environment decorated in contrasting colours may help people's orientation and support their independence. People's names were on their bedroom doors and some included a photograph of the person but no further objects of reference People's bedrooms were personalised with pictures, photographs or items of personal interest. However we saw no evidence of anyone's individual or personal interests integrated into the home outside of their rooms.

We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.

Good

Is the service caring?

Our findings

People said that staff were kind and treated with them with respect. The atmosphere was relaxed with high levels of laughter and banter heard between staff and people. Staff showed kindness to people and interacted with them in a positive and proactive way. One person told us, "If I was at home I would be on my own and lonely. I prefer it here. They are nice and kind."

There was little evidence of formal processes for actively involving people in making decisions about their care and treatment however; no one that we spoke with raised any concerns about this. The manager told us that residents meetings had not taken place recently but they talk to them informally to deal with any concerns. People were involved in making decisions about their daily care. For example, when being offered drinks, or choice of meal. Staff did not rush people for a response, nor did they make the choice for the person.

Staff patiently informed people of the support they offered and waited for their response before carrying out any planned interventions. We observed people smiling and choosing to spend time with staff. Staff knew what people could do for themselves and areas where support was needed. They were able to talk about these without referring to people's care records. For example, a member of staff told us about one person and said, "X needs assistance to eat and drink. Transfers with a hoist. They have dementia and are nonverbal apart from saying no or yes. They use facial expressions to show if happy or in pain. They like tea that is warm, not hot. They have fluids in a beaker. They eat slowly and you have to be very patient." This meant that people were cared for by staff who knew their individual care and communication needs.

Positive caring relationships had been developed between people and staff. The manager told us that they spent time "On the floor" with people (working alongside care staff) in order to build relationships of trust and to monitor how staff treated people. It was apparent that people felt relaxed in the manager's company. The manager ensured they had eye contact with people when talking to them. We heard people asking a member of staff about their granddaughter. The member of staff then showed people photographs of their granddaughter on their mobile phone and a lovely conversation took place with people about the staff and peoples own families. The member of staff explained to us that at times when they were not on duty they had visited the home with their granddaughter and that this had helped build relationships with people. Relatives and friends were encouraged to visit and maintain relationships with people.

People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people's appearance some ladies were wearing items of jewellery that complemented their co-ordinated outfits. Staff were seen offering blankets to people and ensuring their footwear was correctly fitted. We observed that care was given with respect and kindness. We observed staff holding and stroking people's hands. When this happened people who were living with dementia responded positively. One person was observed smiling in response and then cupped the member of staff's face in their hands. It was obvious the person recognised the member of staff and this level of kindness and interaction was the norm. We also observed staff guiding people as they walked along the corridor and talking to them in a calm, kind and reassuring way.

Staff were able to explain how they treated people with dignity and respect and promoted privacy. One member of staff told us, "If helping someone to get changed we do this behind closed doors. We don't let others see them in state of undress. Dignity is important for everyone regardless. If they can't hear properly speak a bit louder but do not scream or shout."

Staff were able to explain how they supported people living with dementia or who had limited verbal communication to make choices about their care. One member of staff explained how they used gestures to communicate with one person and we observed staff using these during our inspection. For example using thumbs up gesture to confirm with the person was happy with the choice of snack provided with their cup of tea. The person responded with a smile. They went on to explain, "We need to help them make decisions sometimes, encourage to them eat. We always talk to people and ask about their family and children. This helps with their memory. It's important to be friends with them, makes me feel good and them too."

Good

Is the service caring?

Another member of staff told us, “Communication is important for people with dementia. We have to be careful to explain things in ways they understand, repeat things. Explain everything before doing anything.”

Requires improvement

Is the service responsive?

Our findings

People told us that they received care and support that was responsive to their needs. One person told us, "I had a fall. I can't remember how it happened. I am here to get better. I started to get in a muddle with things and need help now. I forget what day it is. The staff are nice people. They are helping me to get better." Staff took action to ensure people were comfortable. For example, a member of staff noticed that one person was leaning to the side of the lounge chair that they were sitting in and did not look comfortable. They immediately placed a cushion under the persons head. The person smiled in response.

We saw the care and support were provided to people living at the home. Care was individualised to provide person centred care. One person's care records evidenced that staff had noticed a change in a person's mobility and as a result they had been assessed by a member of the Community Rehabilitation Team. Another person's records stated that staff had at times found it difficult to support the person with their personal care due to the person's low mood. As a result, the person was seen by their GP and their medicines were reviewed.

During the morning of our visit we observed that the majority of people were in the lounge where the television was on. At first this had a music channel on with that no one appeared to relate to. A member of staff noticed that people were not interacting and asked if they would like the channel changed. This was then changed to a food programme and people then started to become more alert. One person was heard to say, "Food nice" and another "Good food." It was apparent that some of the people who were living with dementia were able to relate to this television programme. After this programme had ended the member of staff changed the channel to a film that starred John Wayne. This then prompted people to talk about the film star and other films that he had featured in. Comments made included, "Oh John Wayne, he's a Casanova" and "He usually plays a cowboy, did you see his last film." During the afternoon the television channel reverted back to a music channel that was playing current songs and people became withdrawn and did not appear to benefit from this choice of activity. We raised this with the manager who stated that he would look into it.

During the afternoon a member of staff was observed painting some people's nails. They appeared to enjoy this interaction. Comments included, "Oh look aren't they lovely" and "Pink, very nice."

The manager told us that an external pet therapy session took place on a weekly basis where people were encouraged to interact with a small dog and cat. They also told us that "A volunteer comes now and again to sing to the residents." We were informed that the activities that people participated in were recorded in people's daily records. We viewed the daily records of all people who lived at the home from 10 July 2015 up to the day of our inspection. These did not detail any activities apart from visits by family members.

There was no physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided them with something to do during the day when organised activities were not happening. The manager acknowledged that further work was needed to ensure people received stimulation and enjoyable activities. They told us that, "We are looking for someone full time to do activities."

We recommend that the provider reviews individual hobbies and interests and look at ways and means these could be implemented and people supported to participate.

Some effort had been made to the environment in response to people who lived with dementia. There were four noticeboards located on the ground floor of the home that gave information to people. Some of this was out of date and did not help people who were living with dementia to orientate themselves. For example, in the dining room a notice board stated the wrong date. It also said that the weather forecast was 'summer' but then had a picture of a cloud. Another noticeboard displayed pictures of activities that were available. These included dominoes, listening to music, manicure and pedicure treatments, painting, bingo, church services and sing along. People had access to a variety of books with large print.

Assessments were carried out before people moved into the home and then reviewed once the person had settled into the home. The information recorded included people's personal details and whether people had capacity to make decisions. This was reviewed on a regular basis as people's capacity could vary from to time. Details of health and

Requires improvement

Is the service responsive?

social care professionals involved in supporting the person such as their doctor and or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had up to date information.

People were provided with the necessary equipment to assist with their care and support needs such as wheelchairs, walking frames and hoists. People confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. Information was also recorded if any changes had happened such as: wound care, falls, medicines, incidents, accidents and dietary needs.

People told us that they knew what to do if they needed to make a complaint. People told us that they did not have any complaints and that they felt comfortable to raise issues with staff. One person told us, "I don't like to complain but would talk to any staff as they are nice." Information about the complaints procedure was displayed in the dining room along with information about other agencies that could help people if they were dissatisfied with services. This included contact details for the local government ombudsman and CQC. We saw that information was provided in written form and not in pictorial or other formats which may assist people who have dementia or sensory disabilities to make an informed choice. Staff told us that they were aware of the complaints policy and procedure. Staff we spoke with knew what to do if someone approached them with a concern or complaint. There have been no complaints received in the last 12 months.

There was a letter box at the entrance of the home where people could post concerns direct to the provider with no one else having access to this secure facility.

We reviewed documentation of a resident's meeting held in December 2014 where issues in regards to food and activities were discussed. There were records of action taken. We also reviewed a relatives meeting held in June 2014, information was recorded about relative's opinions about the care their relatives were receiving. Comments included "X is very happy with his mum's care". We were informed by the manager that a questionnaire had been sent to relatives for their feedback about the service and care provided.

Requires improvement

Is the service well-led?

Our findings

Policies and procedures were in place for staff to follow to help ensure safe and appropriate care was provided to people. However, all those we sampled were out of date and did not reflect current legislation and guidance. We noted that staff had limited understanding of current changes, however the manager had a clear working knowledge of the current changes in legislation to protect people's rights and freedom but the staff did not. The manager told us that the provider was aware that the policies and procedures needed to be updated and had subscribed to an external organisation who would be supplying these in the future. None of the staff that we spoke with were aware of the home's whistle blowing procedures.

During the inspection, the manager informed us that they knew about the CQC's Guidance for Providers on meeting the regulations and the Fundamental Standards, but did not have a copy and that all the guidance in place referred to old regulations. This meant that staff did not have access to up to date information about current legislation.

We noted that there was no robust quality assurance system in place to monitor the management of medicines. The manager told us that they reviewed the medicines on a daily basis but did not record anything. We reviewed daily medication checks carried out by staff on individual service user's medicine records, staff signed to indicate they had checked the record but there was no information recorded about what was found. This meant that there were no systematic arrangements in place to identify issues, review and monitor actions taken.

We saw records of daily, weekly and monthly cleaning schedules which detailed different tasks to be carried out by staff in communal areas and people's room. There was no information recorded of the monitoring of cleaning standards of the home. We also saw maintenance records which identified repairs and maintenance checks to be carried out. Although this information was documented, there was no record of action taken. There were no overall audits which covered areas in health and safety, facilities and care records.

Annual medicines audits had been completed by the supplying pharmacy. The audit completed in September 2014 identified two actions were needed, both of which had been acted upon promptly.

The accident records included an accident audit for 2014. This detailed the numbers of accidents but did not contain any further information. The audit summary did not include any analysis that looked at overall trends or themes to identify what, if any action could be taken to prevent future occurrence. The manager said that no audits of events had taken place for 2015 as he had "Not had time."

We noted that there were three incidents that happened in April, May and July 2015. The manager had not notified the Care Quality Commission (CQC) important events which the service is required to send us by law. This meant that we were not able to effectively monitor the service or identify concerns.

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

The manager told us that they had been managing the home since February 2015. They stated that they were awaiting the return of their criminal records check before submitting his application for registered manager. They explained that since being in post he had prioritised implementing the new care planning system. They said that they aimed for this to be complete by the end of August 2015.

People and staff said that the manager and provider were approachable and open to suggestions. One person said, "The manager is a young boy and I have no problem with him." A member of staff said, "The manager helps us, even on the floor. If we have a problem he advises us and tells us what to do. The owner comes two or three times a week."

Staff said that they worked well as a team. One person said, "We all get on well and residents benefit." Another said, "We have very good staff. I like it here. It feels like a family. We all help each other."

People were involved in how the service was run in a number of ways. The manager told us that questionnaires had been given to relatives and staff but that a return date for these had not been included. With regard to responding

Requires improvement

Is the service well-led?

to suggestions by people the manager told us that a relative had said that activities needed to be improved. This had been taken forward and an activity person was being recruited to facilitate this.

We reviewed documentation of a resident's meeting held in December 2014 where issues in regards to food and activities were discussed. There were records of action taken. We also reviewed a relatives meeting held in June 2014, information was recorded about relatives opinion about the care their relatives were receiving, comments included "X is very happy with his mum's care. "We were informed by the manager that a questionnaire had been sent to relatives for their feedback about the service and care provided.

Minutes of a staff meeting held in November 2014 identified actions taken from suggestions made, for example staff were happy with the new chairs that had been delivered, carpets had been deep cleaned by a professional and a new hoist had been received.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider failed to have effective systems in place to safely store and manage medicines. Regulation 12 (1) (2) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured good governance in the home.**