Leonard Cheshire Disability

St Bridget's - Care Home Physical Disabilities

Inspection report

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Ratings

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

Overall summary

The inspection took place on 11 and 13 August 2015 and was an unannounced inspection.

St Bridget's - Care Home Physical Disabilities provides accommodation and personal care for up to 38 people. The service consists of a main building split into three wings and separate bungalows. The bungalows are set up for people to live more independently and can be used for transition into or out of the service. At the time of our visit, there were 32 people in residence, including one person on respite care.

The service had a registered manager. 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.

We identified issues with how the quality and safety of the service was monitored. The registered manager did not have an effective governance system in place to ensure that all aspects of the service were assessed and to mitigate risks to people's safety. People's care records did not provide consistent information to staff on how to meet their needs and there was no record of some agreed support being delivered. We also observed that medicines were not always locked securely when unattended and that staff lacked guidance on the application of topical creams prescribed to people on an 'as required' basis.

People spoke positively about the staff who supported them but were unhappy about the recent use of agency staff. They had raised their concerns with the registered manager who had apologised and explained that agency staff had been used to maintain staffing numbers in a period of staff sickness and holiday. The registered manager had identified that additional staff were needed at particular points in the day and was completing their analysis. **We have made a recommendation about staff deployment to ensure that people's needs are met in a timely way.**

Staff received regular training and were supported in their roles. They spoke of a strong staff team and valued the support of their colleagues. New staff were given an induction and the opportunity to shadow experienced staff until they were confident and assessed as competent in their role

Following an incident in May 2015, the service had worked closely with the safeguarding team and with external healthcare professionals. People who were at risk of choking had been referred to the Speech and Language Therapist (SALT). Staff had also attended training in food textures, providing support at mealtimes and emergency first aid. People were happy with the choice of food on offer at the service. They were also able to use a residents' kitchen to prepare their own meals if they wished.

There was an open and positive atmosphere at the home. People and staff appeared relaxed and happy in each other's company. People and staff felt able to raise concerns with the registered manager and were confident that action would be taken. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.

Staff understood how people's capacity should be considered and had taken steps to ensure that their rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to be as independent as they were able and to make decisions relating to their care and treatment.

People were supported to participate in activities that interested them. In addition to a varied activity programme, the service had a team of volunteers who assisted people individually or in groups.

People's mobility needs had been considered in the design of the premises. The corridors were wide and bedrooms were equipped with tracking hoists. People were able to open key-coded doors as sensors had been fitted to their wheelchairs. A new button-operated system for opening and closing bedroom doors had recently been installed to promote people's independence.

People were supported to access healthcare services. The service also provided in-house physiotherapy and occupational therapy services which were available to everyone who lived at the home at no extra cost.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the 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 safe in all areas.

Risk assessments were in place but people may not be protected from harm as their care records did not always contain the most up-to-date guidance on how to mitigate the risk.

Medicines were not always managed properly or safely and there was unclear guidance for staff on the use of barrier creams.

There were not enough staff at all times of day to meet people's needs in a timely way.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Is the service effective?

Good

The service was effective.

Staff received training to carry out their roles and received regular support from their managers.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of nutritious food and drink.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care and encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People could not be certain to receive personalised care that met their needs because records detailing their needs were inconsistent.

Activities and outings were tailored to people's individual needs and interests and people were supported by volunteers to pursue their individual interests.

Summary of findings

People were able to share their experiences and were assured of a swift response to any concerns.

Is the service well-led?

Requires improvement

The service was not well-led.

The quality assurance system was not effective at monitoring and improving the quality of the services provided.

The registered manager worked collaboratively with people and staff.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

St Bridget's - Care Home Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 13 August 2015 and was unannounced.

Two inspectors and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we reviewed three previous inspection reports, the initial findings of a safeguarding enquiry involving the service and notifications received from the registered manager. 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 any potential areas of concern.

We observed care and spoke with people, their relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for four people, medication administration records (MAR), monitoring records of people's behaviour and weights, accident and incident and activity records. We also looked at three staff files, staff training and supervision records, staff handover records, agency induction records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 10 people using the service, seven relatives, the registered manager, the care supervisor, two team leaders, six care staff, the physiotherapist, the activity coordinator, the volunteer coordinator, two volunteers, the chef on duty, one kitchen assistant and two representatives of the provider. Following the inspection, we contacted professionals to ask for their views and experiences. These included a GP, a Speech and Language Therapist (SALT), a District Nurse and one Social Worker who had involvement with the service. They consented to share their views in this report.

St Bridget's - Care Home Physical Disabilities was last inspected in August 2014 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

Before a person moved to the home risks relating to their personal care and to the environment were assessed. People had been involved insofar as possible in discussing and planning how to manage risks to their safety. One person told us, "I have freedom but I know I can't go to the village alone". In another person's care plan we read, 'I need someone to stay with me while I am smoking'. A third told us that following a discussion with staff they now ate most of their main meals in the dining room rather than cooking their own meals as they had been losing weight.

Where risks had been identified, such as in moving and handling, the use of bedrails or fire evacuation, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, moving and handling care plans detailed the number of staff needed to support the person, the equipment to use and guidance on how to carry out the transfer. People had individual emergency plans in place and staff were able to describe how they would respond to an emergency such as a fire. Staff had attended fire safety training in March 2015 and a major evacuation practice with the local fire brigade in attendance was planned during August 2015. This meant that the registered manager would be able to address any issues with the evacuation plans in place and take action to minimise the risk to people.

Following input from the Speech and Language Therapy (SALT) team, updated guidance was in place for people identified as at risk of choking. This detailed how to minimise risk, including through modified textures such as pureed meals, thickened drinks or continuous staff supervision during mealtimes. Staff had attended recent training run by the SALT to help them understand dysphagia (difficulty swallowing), food texture descriptors and how to support people at mealtimes. There had also been additional emergency first aid training which included learning how to perform the Heimlich abdominal thrust on the 'Choking Charlie' manikin. This training was tailored to the needs of the people using the service and included specific advice on how to perform the manoeuvre when people are seated in a wheelchair.

We asked staff about people's support needs, including who required assistance to eat and who required continuous supervision. We did not always receive consistent answers. We also found discrepancies in some records. For example, in one person's records the SALT guidance stated that they should have their fluids thickened to stage two; though the quantity of thickener had been updated the care plan advised stage one. Another person's risk assessment for the person feeding themselves had not been updated to advise that supervision was required, as per the SALT assessment. A third had a risk assessment for choking but there was no mention of this in their eating and drinking care plan. We found that significant progress had been made in promoting people's safety in the food and drink that they consumed but that further work was needed to ensure that all staff were aware of people's support needs. The SALT told us, "It has been rewarding and we are making changes but there are more checks and balances that need to come in".

Where people were at risk of malnutrition, monitoring was not always effective. There was mixed guidance in people's personal plans, directing staff to weigh people at monthly intervals in the care plan and at three monthly intervals in the health records. In one person's weight records there was a note which read, 'Check in one month, has been referred for advice from the SALT team'. The next weight recorded was three months later. In another care plan we saw that the person was, 'On a food chart from today' but this had not been acted upon. Staff had assessed people's risk of malnutrition using the Malnutrition Universal Screening Tool (MUST) but there was no guidance on how this should be used. We saw that the assessment had been completed annually. Unplanned weight loss had not triggered a review of the person's risk of malnutrition. The registered manager told us that the service had requested guidance from the provider's nurse advisor on how best to use the MUST.

We found that more work was needed to ensure that risks were regularly assessed and managed in a consistent way. This represents a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines were not managed safely. We identified issues with the management of topical creams, specifically barrier creams, which had been prescribed to support people's tissue viability care. These were administered by the care staff but guidance was not always in place to direct staff as to where and when they should be applied. We

Is the service safe?

visited three bedrooms and checked the prescribed creams. In each case we found cream which was to be applied 'as per chart' but there was no chart available. In one case there was a chart but the cream was not available. This could mean that creams may not have been administered in line with the instructions of the prescribing GP. We also found that the creams had not been dated on opening. Records indicated that one cream was used very infrequently, just eight times since October 2014. We were unable to determine when the last tube of the cream was received by the home. This could mean that creams were stored after opening for longer than recommended in the manufacturer's guidelines and their effectiveness may be reduced. There was a lack of clarity around the management of topical creams which meant there was a risk that vulnerable areas of people's skin may not have been adequately cared for.

We observed the administration of medicines over the lunchtime period. There were two staff members administering medicines, each from a separate trolley. One staff member left the key in the trolley when they went to give a person their medicines. The other staff member left the trolley open whilst they were elsewhere in the dining room. This presented a risk that people or visitors may be able to access the medicines. The provider's policy stated that, 'Medicines cupboards and medicines trollies are to be kept locked at all times when not in use or left unattended'. This was not being followed. When we returned on the second day, the registered manager had arranged competency checks for staff and booked refresher training in medicines administration.

We found three gaps in the records of administration of oral medicines. Staff told us that any gaps would usually be identified and addressed during the weekly checks of charts undertaken by the care supervisor. We looked at a record of weekly checks and noted that the last one recorded had been on 23 June 2015. There was no evidence that these gaps had been identified and there were no supporting explanations as to why the medicine had either not been administered or recorded.

The above meant that there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of the above issues, medicines were handled safely and correctly. People told us that they received their medicines regularly and that they were offered pain relief. Only trained staff administered medicines. The competency of these staff was checked annually by the care supervisor. Staff administered medicines to people in a discreet way and stayed with them until they had taken them. Medication Administration Records (MAR) included a recent photograph and information on any allergies the person had. Some people had medicine prescribed 'as required' (PRN). There were clear instructions for staff describing when to use these medicines, the dose and the expected effect. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment.

When new stock was received it was checked in by staff who had been trained to do this and had protected time to complete the task. Medicines were kept securely in a locked room and those requiring refrigeration were kept in a separate locked fridge. The room was clean and ordered. The temperature of both the room and the fridge were monitored and had been maintained within safe limits. Controlled drugs (drugs which are liable to abuse and misuse and are controlled by legislation), were stored securely in a separate locked cupboard fixed to the wall and were accurately recorded.

People told us that staff were generally available to support them when needed. One said, "You can always find someone". A staff member said, "I feel they are safe but they could have more one to one time". There was a daily allocation of staff which included responsibilities for medicines, serving breakfast and supporting people in the bungalows and each wing of the building. The registered manager was able to adjust the staffing levels for ad hoc events if required. On the day of our visit an additional staff member was on the rota as they had accompanied a person to London to participate in an interview panel with representatives of the provider. The rotas demonstrated that the total staffed hours were in line with the assessed hours of care identified as required to meet people's needs. We found, however, that staff were stretched at certain points in the day and that the service was currently using higher than usual agency cover due to a combination of staff sickness and the peak holiday period. These factors were having an impact on how people felt about the care that they received.

The registered manager was aware of the concerns people and staff had about the current staffing level and make-up. The registered manager had used agency staff to maintain

Is the service safe?

sufficient staffing levels. The level of agency use was relatively low but had been felt by people as they were used to being supported by a regular staff team. In the three weeks prior to our visit, 14 percent of early shifts, eight percent of late shifts and two percent of night shifts had been covered by agency staff. One staff member said, "We hadn't had agency here for a very long time". Another told us, "We mostly have enough staff, so long as no one is off sick and we've got enough of our own staff things go well". Some people had raised concerns over the use of agency staff with the provider and a further meeting with a representative of the provider was scheduled.

On the first day of our visit we observed as lunch was served. We saw that one person who required assistance to eat waited for 40 minutes at the table before a staff member was available; another waited 35 minutes for a cup of coffee that they had requested. A staff member told us, "We're not short staffed today and we don't have agency". They told us that more people had been assessed by the SALT as requiring support or supervision at mealtimes but the staff numbers had not increased. We discussed this with the registered manager. They told us that they were reviewing the staffing levels at lunch and dinner time as well as on some evenings when people finished a group activity and wished to be supported to bed directly afterwards. They showed us the work that had been started. This included an analysis of call bell response times and an observation completed by a representative of the provider. **We recommend that the provider accelerate their review of staffing levels to ensure that sufficient numbers of staff are deployed to meet people's needs at all times.**

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers. New staff members had a three month probationary period and did not work alone until they had been assessed by their mentor as competent to do so. These measures helped to ensure that new staff were safe to work with adults at risk.

People told us that they felt safe at the home. One said, "This is my home and I feel safe". Another told us, "I feel well protected and secure". Prior to our visit, the registered manager had notified us of some safeguarding incidents that had occurred at the service. The service had worked closely with the local safeguarding team and had taken action to mitigate the risks. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One staff member told us how they had raised some concerns with the registered manager who had responded quickly to keep the person safe and had alerted the appropriate authorities as required. Safeguarding information was available to staff and leaflets in the reception area provided guidance on 'What to do if you are concerned about someone's safety'. We found that the registered manager and staff team understood their responsibilities and took action to keep people safe.

The provider had a reporting system for accidents and incidents. This meant that all incidents were scrutinised by external colleagues and that learning could be shared. Staff were aware of how to make a report. The registered manager told us that, "They come back with questions or to ask for more information". Learning from incidents was shared across the provider's services via a 'Shared Learning Bulletin'.

Good

Is the service effective?

Our findings

Staff spoke positively about the training they received. One said, "It's really good here for training". Another told us, "We're always doing training, most of it is pretty interesting to be honest". Staff completed courses made mandatory by the provider which included moving and handling, infection control, fire safety and safeguarding. The computer training record identified when each staff member was next due their refresher training which helped to ensure that all training was up to date. Some training, such as in using gastrostomy feeding tubes and catheters, had been provided by the district nurses or other specialist nurses. Other tasks including the use of suppositories and enemas had been delegated to specific staff members by the district nurses. The district nurse told us, "(The care supervisor) has been supervised by us and deemed to be fine to do it, but she won't do anyone else she hasn't been assessed with". A relative of one person who had a gastrostomy said, "They're all interested in getting it right, there is no complacency".

Staff were encouraged to undertake further training relevant to their role. One staff member said, "I also did an Epilepsy one and one about Acquired Brain Injury (ABI)". Another said, "It's one of the better places for training. I've done quite a few short courses through (a local college). I did one on Diabetes and another on common health problems such as Parkinson's". Some staff expressed that they would like further focused training, specifically around conditions that affected the people they supported and in British Sign Language (BSL). The registered manager confirmed that additional courses were being looked at. The provider had recently introduced management training courses, one for supervisors and team leaders and one for senior managers. Some staff from the service were enrolled on these courses.

New staff were supported. Their induction included a welcome day with an introduction to people and colleagues, documentation, use of the call bell, fire procedures, confidentiality, policies and procedures and managing seizures. It also included training on bed rails safety awareness, data protection, whistleblowing and moving and handling theory. All new staff had a minimum three month probationary period where they shadowed experienced staff and received training. One supervisor told us, "You stick with them until you feel they can be alright on their own". Their progress was formally reviewed each month by their supervisor. Their contract of employment was confirmed after three months or when they had achieved a satisfactory level and were confident in their role.

All agency staff who were new to the home, received a formal induction by the team leader on their first shift. This included a tour of the building, fire procedures and emergency plans, people who required special monitoring, location of SALT guidelines and associated documentation, demonstration of hoisting equipment and introduction to people using the service. We reviewed the agency induction records over the past two months and saw that all agency staff new to the home had completed their induction.

Staff felt supported by their managers and received regular supervision and appraisal. One staff member said, "It's good, everyone supports each other quite well". In supervision records we saw that the staff member and supervisor had an opportunity to raise items for discussion. Subjects discussed included attitudes and behaviour, training and communication skills. Progress and achievements since the last meeting were noted along with areas for improvement. In the annual performance appraisal, staff were assessed against core competencies such as team work, reliability and customer focus. They also agreed learning and development plans for the next year and set timescales for achievement of the goals set.

Staff spoke with people and gained their consent before providing support or assistance. Staff explained that if people were unable to communicate their wishes verbally they used facial expression, mannerisms and responses from their communication aids to understand their views. They told us that if someone refused their assistance they would respect their decision but would return later and offer support again. If the person continued to refuse they would document it and inform the senior staff. We found examples of when the service had assessed a person's capacity to make particular decisions. Staff had discussed the risks with people and they had demonstrated their agreement by signing or stamping the risk assessment. One person liked to eat alone in bed which put them at an increased risk of choking. Another person had decided not to wear their lap belt when they used their wheelchair. One

visiting professional told us, "They are very aware of mental capacity and encouraging residents to express their wishes, support autonomy and where a resident has capacity, respecting that".

The requirements under the Mental Capacity Act (MCA) 2005 and associated legislation, Deprivation of Liberty Safeguards (DoLS) had been discussed in staff meetings and guidance had been shared with the team. We saw that five DoLS applications had been submitted. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The home had received decisions on two applications from the local authority. Staff had a good understanding of their responsibilities under this legislation. Where people lacked capacity to make particular decisions, best interest decisions involving relevant professionals and the person's relatives had been arranged. One person used a powered chair but staff controlled it, another had undergone an anaesthetic for dental treatment and a third had their food presented in a way that made it safer for them to eat

People were happy with the choice of food available. One said, "The food is usually pretty good, you do get a choice". Another told us, "There's no problem with the food, the roast dinners are very nice". People were asked to let the kitchen know before 10.30am if they wished to have something other than what was on the menu. In the communication book we read the one person's evening choice was, 'Jacket (tuna), no butter please'. Another had requested, 'Some crackers and the butter in a little pot with hard cheese for her packed lunch and red grapes'. One of the kitchen staff told us, "You work with the residents all the time so you know what they want". They explained that some people purchased ready meals, used the residents' kitchen to prepare their own meals or had food prepared for them by their relatives. The SALT told us, "They are trying to provide a lot of variety, in many ways they are creating bespoke meals".

There was a folder containing swallow guidelines for people who had been identified as at risk of choking and assessed by the SALT. Kitchen staff had received training in producing different food textures and a new blender had been purchased so that they could achieve a smooth pureed meal. One of the kitchen staff told us, "We've had the different textures so we could taste for ourselves". They told us that they would show the person their meal before putting it through the blender so that they could see what they were eating. We observed that some people had adapted plates, cutlery, cups or non-slip place mats to assist them in eating or drinking independently. Specific dietary needs or preferences were catered for, including vegetarian and gluten-free meals. Drinks were readily available. A relative of one person who had been at risk of dehydration told us, "The focus on him at St. Bridget's was fantastic. They were willing to sit with him for 40 minutes, 50 minutes or an hour (to support the person to drink). I can't praise them enough for that".

People had access to healthcare professionals to ensure that their health needs were met. Staff told us they were able to access support and advice from the GP, District Nurse, Dietician, SALT and the psychiatric service. People had attended health and medication reviews with their GP. Physiotherapy and Occupational Therapy services were provided in-house and were available to all at no additional fee. Professionals that we spoke with told us that staff sought advice and followed their recommendations. A District Nurse said, "They're very prompt, they follow advice". A GP told us, "Everything I have asked to be done seems to have been done". A social worker said, "If they can't manage, they refer back. They are willing to work with people and learn from people".

The home was made up of the main building with its three wings and three bungalows for those capable of more independent living. One person who lived in the bungalows told us, "I have peace and silence at my place. It's my own little place". The buildings were bright and airy and the registered manager told us that laminate flooring had been recently installed in all communal areas to ease cleaning and to increase safety for people using the service. People had free access around the building and to the garden areas. Although two external doors had key pads, the registered manager told us that everyone (with the exception of those subject to DoLS) had access to proximity sensors fitted on their wheelchairs so that the doors could be opened when required. All rooms had profiling beds, tracking hoists, call bells and automated doors, recently installed and adjusted to improve independent access for wheelchair users.

The home had a well-equipped gym managed by their permanently employed physiotherapist. We saw two people using the exercise machines to maintain their

Good

Is the service effective?

mobility and increase their strength and one person who had requested to have a relaxation session with soothing music. The home also had a hairdressing salon but staff told us that most people preferred to go a local hairdresser in the village when they needed a service.

Good

Is the service caring?

Our findings

There was a happy atmosphere at the home during our visit. One person told us, "I know which ones (staff members) I can have a laugh with!" People and staff appeared to enjoy each other's company and were engaged in a variety of activities and tasks. We asked one person what it was like to live at the home and they said, "It's brilliant". When we asked why they said, "The staff". Staff demonstrated understanding and skill in communicating with people. When we wanted to wish one person a happy birthday, staff assisted us using a combination of sign language and lip reading. Relatives spoke positively about the staff. One said, "The carers are so friendly with (their relative). Their humour is great and he is always laughing". Another told us, "They mind about him, they listen to him".

People had personalised their bedrooms with photographs, pictures and personal items that reflected their interests and pastimes. One person's room had a large desk, computer, books and a large screen TV while another was clearly a football fan. Staff were able to talk about the people they cared for, describing what time they liked to get up, which activities they liked to join in with and their preferences in respect of food. They also knew about their family and friends and some of their interests. One the day of our visit staff were assisting one person to send a card to their new nephew. We observed staff treating people with kindness and compassion, taking time to talk with them, listen to them and explain what was happening. We attended part of the staff handover. Staff discussed the people they had supported during the shift in a caring and compassionate way.

When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. People's care plans provided information on their needs and preferences. They included information such as, 'What is important to me', 'My favourite things', 'Fondest memories, 'I like', 'What I don't like'. They described how people communicated. We read, 'Able to communicate but does so quite slowly so allow him time to express himself' and, 'If I wiggle my right index finger this means no'. There was also detail on their preferred morning and night-time routine. We read, 'Wait until 8.30am until you ask me if I want to get up' and, 'I like my TV on when getting up'. A relative told us, "Some carers know he wants a cup of tea when he rings and will just bring it".

Each person had a staff member designated as their keyworker. This staff member was responsible for ensuring the person's well-being and spending one to one time with them. Most people and relatives were happy with the system. One relative said, "They pride themselves on giving individual care and they do it. His keyworker inspires confidence". Another told us, "The keyworker is brilliant, she understands my daughter and has a very mature attitude". People had been involved in planning their care and many had signed their care plans and risk assessments to demonstrate agreement.

People were encouraged to be as independent as they were able. Care plans described the tasks they were able to do and those where they required support. We read, 'I like to wash my face and then will require help with the rest of my body'. A social worker explained, "They've given (person living at the service) really good opportunities. They have done a great positive risk assessment for her accessing the community on her own". They told us that measures included the person taking their phone with them, providing staff with the time they expected to be home, checking they had money with them and, if it was hot, making sure they had sun cream on. Some people had equipment to support them, including a speech activated computer, television and telephone. The new automated bedroom doors installed throughout the home were button operated which allowed people to control the door independently.

Staff treated people respectfully. They addressed people by their preferred names and gave them time to consider and respond to questions. Staff were able to describe how they maintained people's privacy and dignity by knocking on doors and waiting to be invited in before entering. One person said, "They always knock and ask for permission". If people had expressed a preference for male or female support staff to assist them, this was respected. Most people kept their care records in their bedrooms which gave them control over their personal information. We noted that an action from record keeping audit in June

Good

Is the service caring?

2015 was to ask people when they would want relatives and friends called if they were unwell. One relative told us, “My daughter was told she had the right to keep her plan private so I don’t have any input”.

Several staff told us that the introduction of the automated doors with a 10 second delay in closing had impacted on their ability to maintain people’s privacy and dignity at all times. For example, if they needed additional items not available in the room when providing personal care, the door remained open for a short period. This could compromise the person’s privacy even though staff made every effort to cover them up to protect them. We discussed this with the registered manager and the maintenance staff. We found that the concern was being addressed and that the doors were due to be recalibrated.

Requires improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent care and support because guidance on the support they needed and records of the care delivered were not always consistent. There was conflicting information on how often to weigh people and on when to intervene with medicine when a person had not had regular bowel movements. In one person's care plan it stated that a laxative was to be given if the person had not had a bowel movement for three complete days. In the same person's medicines care plan it stated to give one sachet if they had not opened their bowels for two days. We checked a gap on their bowel chart with the MAR and saw that a laxative had been given only after six days with no bowel movement. Another person was due to have five minutes of vocal exercises daily and 10 minutes of walking twice daily. The care plan stated that they should be supported to do this by care staff and a record kept. There were no records in place which meant that we were unable to be sure that the person received the regular support they needed to maintain their health.

The care plans that we looked at were rarely dated. When changes occurred they were not always reflected in all areas of the person's record. For example the hospital passport for one person who now used a gastrostomy tube for nutrition and fluid had not been updated to reflect this. A best interest decision dated November 2013 stated that a full assessment by an external professional was needed. The best interest decision had been reviewed three times, most recently in April 2015, but there was no reference to the outcome of the assessment. A relative told us, "It's hard to get instructions kept to - it works for a bit and then drops off. They are always willing to listen and very often the first week it will happen but then there can be slippage". We found that the records describing how to support people were not always reliable and did not ensure that people received consistent support to meet their needs.

The service had not maintained completed and contemporaneous records in respect of each person, including records of the care and treatment provided and decisions taken in relation to their care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had identified that the records were not always complete and work was underway to rectify this, including by reviewing which care plans individual team leaders were responsible for updating. One staff member told us, "The records are a lot better than they were, it's easier to find information you need with the index and files have been updated". Staff told us that they attended the handover at the beginning of each shift with the senior member of staff on duty. They said they were able to obtain additional information by reading the daily records completed by the care staff on the previous shift, reading the communication book and looking at the handover sheet which included information about people and their care from the previous shifts. One staff member said, "Most things are in the communication book, generally I know what is going on".

Staff were trained to respond to changes in people's behaviour and to support them appropriately.

Staff had received training in the management of behaviour which challenges and were able to respond effectively. They described how they would use de-escalation techniques such as talking calmly to the person, trying to distract them and, if necessary leaving them alone for a while to calm down, in easy reach of a call bell. One staff member said, "I feel confident to calm people down". The service maintained records of behaviour that could be described as challenging and had used this evidence to make a recommendation for one person to receive one to one support at a particular time of day. The recommendation had been accepted and as a result the person was receiving additional support.

People were supported to engage in activities that interested them. One staff member said, "Everyone does different things". They told us about one person who had recently started to go to a shooting range and others who enjoyed watching football matches at the local pub. We saw that a vacant bedroom had been adapted with special flooring and transformed into an art studio for a person who enjoyed making models. The service had an activity co-ordinator who organised a wide range of activities for people, including arts, crafts, music, quizzes and games. These took place in two large dedicated rooms. The service had a computer room which included eye-gaze technology and was very popular with many residents, who used it to communicate with friends and family, to update social media or to watch online videos that interested them. During our visit we saw a cookery session when someone was cooking a favourite dish under supervision and a craft

Requires improvement

Is the service responsive?

group where people were creating pictures with buttons. One person brought their completed work for us to see and said how much they had enjoyed the session. The activity co-ordinator also organised events such as discos and barbeques. Photographs of these events and outings attended by residents were displayed around the home.

The home had an active group of volunteers who were supported by a volunteer co-ordinator to facilitate activities with people living at the home. Volunteers provided one to one sessions with people, befriending them and taking them shopping, out for walks or other activities of their choice. They also ran games sessions, did volunteer driving and organised a Saturday club twice a month supported by young people including those undertaking Duke of Edinburgh awards. In the volunteer report we read, 'A new volunteer has developed a good relationship with a resident who is very quiet but enjoys having the newspaper read to him and then discussing the local news'. One person told us, "There are lots of opportunities". A staff member said, "We are really lucky here with volunteers, they get a lot of one to one time".

In August 2014 people had been offered the opportunity to speak with an external representative to discuss their views and wishes. As a result a driver was now employed on a Sunday to take people to church and one person had started to visit a local horse centre. A social worker said, "They're very activity based. They've done lots of day outings with my client and she goes out for dinners. They use volunteers really well, they get that one to one time".

People told us that they were able to speak to staff if they had concerns. One said, "I know that I can talk to someone". A relative told us, "They are fantastically easy to talk to, all of them. They are very receptive". There were regular resident meetings. We saw that the use of agency staff had been discussed and that people had received an apology and explanation from the registered manager. One person told us, "We are involved with care plans and have residents' meetings to express opinions". At the time of our visit no one was using the services of an advocate but we saw that the service had previously arranged advocacy support for people to support them in expressing their views and wishes. People and their relatives told us that issues they raised were generally resolved promptly. One relative said, "(The registered manager) sorted it out and he got back to me quickly".

People understood how to complain and felt confident to do so. Leaflets describing the process were available in the reception area. We saw that the few complaints received had been dealt with appropriately and in accordance with the timescales set out in the policy. Staff were aware of the complaints policy and procedures. They knew what to do if someone approached them with a concern or complaint and had confidence that the registered manager would take the complaint seriously.

Requires improvement

Is the service well-led?

Our findings

The registered manager did not have an effective system in place to monitor the service that people received and ensure that it was consistently of a good standard. There had been a number of audits carried out but there was no structure to ensure that all aspects of the service were monitored or to ensure that identified actions were completed.

Following an incident in May 2015, the service had worked closely with the local safeguarding team and with external professionals to improve the safety of the service they provided. There was an action plan in place and representatives of the provider were visiting to work with the registered manager on its completion. Recently introduced audits included an infection control check, a compliance audit against the regulations and an audit of people's personal plans. Actions had been identified, including a review of staffing levels and of people's care records. These actions were included on a performance improvement plan created on 9 August 2015. We saw that work was underway to address the issues but no target date had been set for completion of the work.

Where regular audits were in place these had delivered improvements. A monthly health and safety audit considered accident reports, moving and handling practice, fire and infection control. As a result work had been carried out or scheduled. This included the new flooring recently in place, an order for a replacement sluice and a new smoking shelter. The registered manager also carried out spot check visits at weekends to ensure that the service was running smoothly. There had also been progress against external audits, such as the implementation of a regular flushing regime by the maintenance team to reduce the risk of Legionella and temperature recording of the medicines room following a pharmacy audit.

We found, however, that other regular checks, such as the weekly check on medicines had not been completed for over a month. This had not been identified by the registered manager. During our visit we identified some areas of concern, including the medicine trolleys not being secured and a lack of guidance around topical creams. The registered manager took prompt action to address the concerns. On the second day we visited safe medicine storage had been discussed with staff and individual staff members had undergone competency checks and had been booked on refresher training.

The registered manager and provider were keen to improve the service and responded openly to concerns that were raised. At the time of our visit, however, there was not an effective system to assess, monitor and improve the quality and safety of the services provided and to assess, monitor and mitigate the risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, staff and relatives spoke positively about the registered manager. A staff member said,

"I feel I can go to him, if he can he will try to resolve it there and then". Another told us, "He's a good manager because he is always hands on". A relative told us, "He is approachable and will answer you" and said, "He's got it totally at heart". One person said, "I would trust my life with him – the trouble is he is too nice to everyone". This feeling was echoed by other people that we spoke with during the visit. Others spoke of the difference the registered manager had made to the service. One staff member said, "He's got no problems getting things done". The SALT we spoke with said, "He has been committed and proactive".

The registered manager was supported by a team including a care supervisor, an administrator, head chef, housekeeper and head of therapy team. Representatives of the provider also visited the service to provide support. Staff told us they had regular staff meetings when they discussed any issues about the service, their work, any proposed changes and shared new information. They told us they had an opportunity to bring up suggestions for improvement at these meetings.

There was a happy and open atmosphere at the home. The registered manager was readily available and was happy to stop and talk with people or provide them with support. One person told us, "You couldn't find a better place". People were involved in the service, some by participating in interview panels for new staff, others by working in the charity shop on site which raised funds. One staff member told us, "It's a fun atmosphere, there's a lot to do".

Staff were positive about working in the home. One said, "We aim to provide the best care so that people can have the same quality of life that we have". Another told us, We

Requires improvement

Is the service well-led?

give good care here and we have a core of great long term staff which people like". They spoke enthusiastically about the availability of activities, specifically the computer room and the in-house physiotherapy. Staff felt supported by their colleagues and said that everyone helped each other. Staff were aware of the whistleblowing policy and on how to raise concerns. They told us that they felt confident to do this and some shared examples of issues they had raised with the registered manager. One said, "The manager would definitely respond if I had any concerns". Staff also told us that the area manager visited the home regularly and they would be happy to raise any issues with her if necessary and were confident she would address them.

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 Risks to people's health and safety had not been fully assessed or mitigated. Regulation 12 (2)(a)(b). Medicines were not always managed properly or safely. Regulation 12 (2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The system to assess, monitor and improve the quality and safety of the service provided was not effective. Regulation 17 (2)(a). The system to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others was not effective. Regulation 17 (2)(b). The service had not maintained a complete and contemporaneous record in respect of each person, including records of the care and treatment provided and decisions taken in relation to their care and treatment. Regulation 17 (2)(c).