Care Quality Commission

Abbeyfield Hoylake & West Kirby Society Limited

Abbeyfield Lear House

Inspection report

17 Darmonds Green
West Kirby
Wirral
CH45 5DT

Tel: 0151 625 1883
Website: www.example.com

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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?	Good
Is the service well-led?	Good

Overall summary

We undertook this comprehensive inspection on the 13 and 18 November 2015. The first day of this inspection was unannounced.

Abbeyfield Lear House is registered to provide personal care and accommodation for up to 29 people. The home is situated in West Kirby, Wirral. It is within walking distance of local shops with good transport links. There is a small car park and garden available within the grounds. A passenger lift enables access to the bedrooms located on the first floor for people with mobility issues.

Communal bathrooms with specialised bathing facilities are available on each floor. On the ground floor, there is a communal lounge and dining room for people to use. Upstairs, there is another small lounge for people to use if they wish. The home is decorated to a good standard throughout.

On the day of our visit, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Summary of findings

Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived at the home said they were well looked after and they were treated with dignity and respect. We saw people were supported to maintain their independence where possible and they had a choice in how they lived their lives at the home. There was a range of activities on offer at the home and the home had a social and relaxed atmosphere throughout.

People told us they felt safe at the home and had no worries or concerns. From our observations it was clear that staff genuinely cared for the people they looked after and knew them well. Staff spoken with, were knowledgeable about types of abuse and what to do if they suspected abuse had occurred.

People had access to sufficient quantities of nutritious food and drink throughout the day and were given suitable menu choices at each mealtime. People's special dietary requirements were catered for and people we spoke with told us the food was good.

The home had the majority of medication supplied in monitored dosage packs from the local pharmacy. Records relating medications were accurate and completely legibly. All staff giving out medication were medication trained.

We observed a medication round. We saw that the way in which medicines were administered, required improvement. The staff member undertaking the medication round was constantly interrupted which increased the risk of a mistake being made. Medicines were also observed to be signed for by the staff member before being administered to people who lived at the home. This meant the staff member had recorded that they had observed the taking of this medication before it had been consumed. This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities Regulation 2014) as medicines were not administered safely.

Staff were recruited safely and there were sufficient staff were on duty to meet people's needs. Staff had received the training they needed to do their jobs safely and were appropriately supported in the workplace.

We reviewed three care records. Care plans were person centred and provided sufficient information on people's needs and risks. Staff were given clear guidance on how to care for people and meet their needs. We saw that people's preferences and wishes in the delivery of care had been listened to and care had been designed so that these preferences and wishes were respected.

Regular reviews of care plans took place to monitor any changes to the support people required and we saw from people's care records that they had prompt access to other healthcare professionals when needed.

We saw that staff asked people's consent before providing support. Where people had mental health conditions that impacted on their capacity to make specific decisions in relation to their care, care plans contained some information about how these conditions impacted on their day to day life. We found however that people's capacity to make specific decisions had not been assessed appropriately when their capacity to make a specific decision was in question. This meant that the Mental Capacity Act 2005 legislation had not been followed to ensure people's legal consent was obtained. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were provided with information about the service and life at the home. Information in relation to how people could make a complaint was available but required the contact details for the internal and external parties people could contact, in the event of a complaint, to be clarified. No-one we spoke with had any complaints. The manager told us no complaints had been received.

The premises were well maintained and the home's kitchen had been awarded a five star rating (very good) by Environmental Health. The majority of equipment was properly serviced and maintained with the exception of Elliott House's electrical system which the provider rectified immediately.

People who lived at the home and staff told us that the home was well led. Staff told us that they felt well supported in their roles and that they were able to express their views. The management of the home was

Summary of findings

well organised, staff were confident in their roles and were observed to work well as a team. The manager was 'hands on' and the culture of the home was homely and inclusive.

There was a range of suitable audits in place to assess and monitor the quality of the service provided. For example, accident and incident audits, medication audits, infection control audit and premises checks. People's feedback was gained through residents meetings and the use of satisfaction questionnaires. We reviewed a sample of the results of the last satisfaction survey undertaken in 2014 and saw that they were positive.

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The premises were well maintained and the home's kitchen had been awarded a five star rating (very good) by Environmental Health. The majority of equipment was properly serviced and maintained with the exception of Elliott House's electrical system which the provider rectified immediately.

People who lived at the home and staff told us that the home was well led. Staff told us that they felt well supported in their roles and that they were able to express their views. The management of the home was well organised, staff were confident in their roles and were observed to work well as a team. The manager was 'hands on' and the culture of the home was homely and inclusive.

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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 generally safe but the way medication was administered to people at the home required improvement to ensure it was safe.

People who lived at the home told us they felt safe and had no worries or concerns. We looked at three care files and found people's risks were assessed and safely managed.

Staff knew how to recognise and report signs of potential abuse. They were recruited safely and there were sufficient staff on duty to meet people's needs.

The environment was safe, clean and well maintained.

Is the service effective?

Requires improvement 

The service was generally effective but the implementation of the Mental Capacity Act (2005) at the home required improvement to ensure people's rights were protected.

People said they were well looked after. It was clear from our observations that staff knew people well and had the skills/knowledge to care for them.

People were given enough to eat and drink and were given a choice of suitable nutritious foods to meet their dietary needs.

Staff were trained and supported in their job role. Staff worked well as a team and the manager had a proactive approach to care.

Is the service caring?

Good 

The service was caring.

People and relatives we spoke with held staff in high regard. Staff were observed to be kind, caring and respectful when people required support.

Interactions between people and staff were warm and pleasant and it was obvious that staff genuinely cared for the people they looked after.

People's independence was promoted and people were able to make everyday choices in how they lived their lives.

People were given information about the home and were able to express their views about the service provided.

Is the service responsive?

Good 

The service was responsive

People's needs were individually assessed, care planned and regularly reviewed. People's preferences and wishes were respected and care was person centred.

Summary of findings

The service was responsive when people became unwell and people received ongoing care from a range of health and social care professionals.

A range of activities were provided and staff interacted positively with people throughout the day either in passing or in direct conversation.

People who lived at the home and the relative we spoke with had no complaints and no complaints had been recorded.

The provider's complaints policy was displayed. The contact details for who people should contact in the event of a complaint needed to be included.

Is the service well-led?

Good

The service was generally well led.

Staff we spoke with said the home was well led and managed. A healthcare professional we spoke with, agreed with this.

A range of quality assurance checks were undertaken to assess and monitor the quality of the service provided. Regular management meetings were held. The minutes of which demonstrated a commitment to continuous improvement.

People's satisfaction with the service was sought. The latest survey in 2014 generated positive results.

A positive and inclusive culture was observed at the home. The manager was 'hands on' and it was obvious from our observations that the manager was well respected by the staff team.

Abbeyfield Lear House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 13 and 18 November 2015. The first day of the inspection was unannounced. The inspection was carried out by one Adult Social Care (ASC) Inspector.

Prior to our visit we looked at any information we had received about the home and we contacted the Local Authority for feedback. On the day of the inspection we spoke with two people who lived at the home, one relative, two care staff and the manager. We also spoke with a healthcare professional who was visiting people at the home on the day of our visit.

We looked at the communal and bedroom areas that people shared in the home. We reviewed a range of records including three care records, medication records, recruitment records for four members of staff, staff training records, policies and procedures and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

We looked at the arrangements for the safe keeping and safe administration of medicines at the home. We saw people's medication was kept securely and at safe temperatures. Medication was dispensed in the majority via monitored dosage blister packs. We checked a sample of three people's medication administration charts (MAR). We found that stock levels balanced with what medicines had been administered.

The manager told us staff received training to administer medication safely. Staff records and the staff we spoke with confirmed this. Records showed that the competency of staff to administer medication safely was also assessed by the manager prior to them being able to administer medication unsupervised.

We observed the lunchtime medication round. The staff member administering the medication did so in a discreet and sensitive manner. We saw however that the staff member constantly interrupted by the telephone and visiting professionals to the home who required assistance. This meant there was an increased risk that mistakes would be made due to the staff member being distracted.

The staff member was also observed to sign the person's medication administration record (MAR) as having observed the consumption of the medication prior to its administration. This meant an inaccurate entry was made in the person's MAR as the staff member had not administered or observed the consumption of the medication prior to signing the record. Staff administering medications should always observe the person taking the medication before they sign the person's medication records.

We spoke to the staff member about this, who acknowledged that they should have signed after administration. They provided assurances that all staff would be reminded of the importance of ensuring medication administration records are signed appropriately after administration.

These incidences were a breach of Regulation 12 as the provider did not have suitable systems in place to ensure the proper and safe management of all medicines in the home.

All of the people we spoke with said that they felt safe at the home. One person told us it was a "Jolly good" place. Another said "I've never regretted coming here". A relative we spoke with said that they had no worries or concerns. They told us, the person who lived at the home was "Content". Throughout our visit we observed that people were relaxed and comfortable in the company of staff. We observed positive, warm interactions between staff and the people they cared for.

We saw that the provider had a policy in place for identifying and reporting potential safeguarding incidents. The policy identified the external organisations staff should contact in the event of an allegation of abuse being made, but failed to provide staff with any contact details on how to get in touch.

We spoke with two staff about safeguarding. Both staff members spoken with understood types of abuse and the action they should take, should an allegation or incident of abuse occur. Training records confirmed that all staff received safeguarding training.

No safeguarding notifications in relation to the people at the home had been submitted to The Commission since the home registered in 2010. We checked that this was correct with the manager. The manager told us no safeguarding incidents had been reported by people who lived at the home, relatives or staff.

We looked at the care files belonging to three people who lived at the home. People's risks in the delivery of care had been assessed and suitable management plans put into place. For example, risks in relation to malnutrition, falls, moving and handling, pressure sores and cognition were all assessed. Care plans were easy to read and gave a good overview of the care people required to keep them safe.

We saw that there were personal emergency evacuation details in place. This information provided staff and emergency services with information about people's mobility needs in order to assist them in an evacuation.

A call bell system was in place in people's bedrooms to enable people to call staff for help and all staff were provided with pagers to alert them when and where a call bell was sounded. We saw that people were encouraged to use the call bell system as and when required. During our visit we found people's needs were met promptly. A staff member was always visible in communal areas and people's call bells were answered in timely manner.

Requires improvement

Is the service safe?

Abbeyfield Lear House is a two storey building offering 24 single occupancy rooms. Lear House also has an annex called Elliot House. Elliott House accommodates five older adults in single occupancy rooms for residential or respite care which are regulated by the Care Quality Commission. It also has three other single occupancy rooms available for people who require sheltered living accommodation. All rooms have en-suite facilities.

People we spoke with thought the premises were well maintained. On the day of our visit, we found that both Lear House and its annexe were clean, warm and of a good standard. The gardens were tidy and well looked after. Lear House had a sensory garden for people to enjoy and a balcony outside of the lounge where people could sit and enjoy the view. We saw that the provider had been awarded a five star rating by Environmental Health in November 2014 for its standards of food hygiene. A five star rating is very good. We saw that the kitchens in both Lear House and its annexe were well organised and managed.

We looked at a variety of safety certificates for the home's utilities and services, including gas, electrics, heating, fire alarm, fire extinguishers and pat testing. We saw that the heating, gas, fire and moving and handling equipment all conformed with recognised safety standards and were regularly inspected and serviced by external contractors at the home. We saw that Lear House's electrical installation had been inspected as satisfactory but that the annexe's electrical system had been inspected as unsatisfactory by an electrical contractor in May 2014.

We spoke to the Chief Executive Officer about this who told us that they were unaware that the electrical installation report stated the installation as unsatisfactory. They acknowledged this was an oversight. They provided assurances this would be resolved without delay. Shortly after our inspection, we received written confirmation from the provider that all electrical faults had been addressed and the electrical installation was now considered safe and satisfactory for purpose.

We reviewed accident and incident records and saw that staff undertook prompt and appropriate action after an accident and incident occurred to ensure people had the support they required. Accident and incident records were completed appropriately and monitored by the manager.

We looked at the personnel files of four staff. All files included evidence of a satisfactory recruitment process. Each file contained an application form, previous employer references, proof of identification checks and a criminal convictions check. Each staff member had a contract of employment and previous experience in a healthcare assistant role prior to employment.

The deputy manager told us that three or four care staff were on duty during the day plus the management team at Lear House, with three care staff on duty of a night time. At Elliott House, a senior member of staff and a member of the care team were on duty during the day, with one staff member supporting people throughout the night if required. An activities co-ordinator also worked at the home and split their time between Lear House and its annexe. Staff rotas confirmed this and were clear and well organised.

We saw that the home and its annexe were adequately staffed. We saw that people were assisted in a patient, friendly manner at their own pace. Staff were unrushed in the delivery of care and we saw that staff had the time to sit and chat to people as well as support them with their personal care needs.

We saw that antibacterial soap and alcohol hand gels were available throughout the home to assist with infection control. The home was adequately clean and there was ample protective personal equipment for staff to use in the delivery of personal care. One person we spoke with told us that they would "Give them top marks" for the cleanliness of the home.

There was evidence that the provider has systems in place to monitor and control the risk of Legionella. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed.

We saw that the provider had appropriately assessed the risk of legionella and put suitable systems in place to enable the risk to people's health, safety and welfare to be managed. The home's maintenance person undertook regular checks of the temperature of the water from the taps. An external company monitored the water temperatures of the hot water cylinders and the temperature at which the water was distributed to ensure it was within the 'safe' range for the control of legionella. This meant the risk of infection was mitigated against.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

There were a small number of people who lived at the home who had mental health conditions that may have impacted on their ability to make specific decisions. During our visit, we checked whether the service was working within the principles of the MCA and DoLS legislation when people's capacity was in question. We found there were some good elements of good practice in relation to dementia care and people's involvement in care planning but that the implementation of the MCA and DoLs legislation required improvement at the home.

For example, one of the care files we looked at indicated the person to whom the care file belonged, lived with dementia. We saw that the risks associated with the person's dementia and its impact on the person's day to day life had been assessed. There was a mental health care plan in place which provided staff with information on what the person could recall and the environment in which the person became distressed or anxious. There was also simple guidance to staff on how to respond to the person when they became distressed. This meant staff had appropriate information and guidance on how to support the person's emotional needs in the delivery of care. The person's care file however lacked adequate information about the person's capacity to make their own decisions and there was limited evidence of discussions with the person about specific aspects of their care for which consent was required.

For example, we saw an application to deprive the person of their liberty had been submitted to the Local Authority. We saw in the person's file, evidence that staff at the home had discussed the deprivation of liberty application with the family but there was no evidence that this decision had been discussed with the person themselves or that they had been actively enabled to participate. There was no capacity assessment in place to identify whether the person was able to participate in these discussions. We asked the manager about this who told us an assessment of the person's capacity to make this decision had not been undertaken. This meant that the principles of the mental capacity act had not been followed.

This person's file also contained a consent form signed by the person's family. For example, consent had been given by the person's family to the person's care plan rather than the person themselves stating the care plan was in the person's 'best interests'. The Mental Capacity Acts 2005 states that relatives cannot be asked to signed consent forms when a person lacks capacity unless they have authority to do so under a Lasting Power of Attorney or a Court Appointed Deputy. Neither of these provisions were in place for this person.

This examples demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have suitable arrangements in place to ensure the principles of the Mental Capacity Act 2005 were followed to gain legal consent, where a person's capacity may be in question.

We spoke to the manager about the implementation of the MCA and DoLs legislation at the home. They acknowledged that this was an area for development and demonstrated a positive commitment to ensure improvements were made.

People we spoke with said the care was good and they were well looked after. One person told us "I wouldn't criticise this place, they try hard". Another told us "The staff are great". The relative we spoke with said "They (the person) never seems to want for anything".

The relative and the healthcare professional we spoke with told us that the home kept in touch and communicated with them well. The relative said that there was "No problem at all" and the healthcare professional told us that they had "Good, open communication" with staff at the home.

We spoke with the manager, deputy manager and two staff about the people they cared for. Staff we spoke with demonstrated a good understanding and knowledge of

Is the service effective?

people's needs. We observed staff supporting people throughout the day and from our observations it was clear that staff knew people well and had the skills/knowledge to care for them.

Staff training records showed that staff had access to regular training opportunities. Training was provided for example in safeguarding, moving and handling, the safe administration of medication, infection control, mental capacity, deprivation of liberty safeguards, first aid, dementia and end of life care.

We saw evidence in staff files that staff received appropriate appraisal and supervision in their job role. This included supervision in specific aspects of care for example, fluids and nutrition, catheter care, deprivation of liberty safeguards and medication administration.

We saw staff throughout the day checking people consented to the support they were being given.

Care plans showed that people had been given a choice in how they wished to be cared for and that personal choices had been respected and built into the package of care they received.

People we spoke with were pleased with the choice and standard of the food at the home and said they got enough to eat and drink. Comments included the food is "Very good indeed" and "Always very nice".

We spoke to the cook. They told us people were given the menu options each day. They said an alternative to the main menu was always available if people did not like what was on offer. People we spoke with confirmed this.

We observed the serving of the lunchtime meal and saw that the meal was served promptly and pleasantly by staff. The dining room was light, airy and the lunchtime meal was served in a relaxed, social atmosphere. The tables were set pleasantly with cotton tablecloths, napkins and a floral centrepiece.

The lunchtime meal was fish, potatoes and vegetables. We saw that the food provided was of sufficient quantity, looked and smelt appetising. People we spoke with thought the food was good and said they had plenty to eat and drink. We observed that one person who did not like fish, was offered a range of suitable alternatives by staff in a pleasant and helpful manner. People were offered additional portions and staff checked that people were satisfied with the meal provided.

Where people required prompting or assistance to eat, staff supported people's needs sensitively, promoting people's independence where possible. For example, we saw that one person was given verbal encouragement to eat and their plate re-positioned during the meal to enable them to reach their food easily with the utensils provided.

We saw that people's nutritional needs were assessed and their preferences noted in the planning and delivery of care. Dietary supplements were available for people at risk of malnutrition and drinks and snacks were provided throughout the day. People were weighed regularly and medical advice sought if people's dietary intake significantly reduced.

One person whose care file we looked at had a medical condition which meant their dietary intake required monitoring. The person had a specific nutritional care plan to ensure that their medical condition was managed appropriately. Staff were given information on what food the person could and couldn't eat and the signs to spot should the person's medical condition impact on their health.

Care plans contained evidence that referrals for specialist advice had been sought in respect of people's care. Referrals to dietary services, heart specialists, continence teams, tissue viability services, mental health services and district nurses had been made in respect of people's health and medical needs. People's daily notes showed that staff monitored people's health and wellbeing on a daily basis and responded appropriately when people became unwell.

The premises was tastefully decorated and adapted to meet people's needs with hand rails in communal corridors to assist people's mobility, a passenger lift and stair lift for accessing upper floors, toilet aids and pleasant communal areas.

The manager told us that the home's roof had recently been renewed and that the home was in the process of undertaking additional refurbishment work. For example, they told us that two rooms at the home had been re-decorated specifically for people living with dementia using Stirling University's dementia research into dementia friendly environments as a guide.

We visited both rooms and saw that some improvements in the way the rooms were decorated had been made to enable people living with dementia to orientate themselves to their environment. For example, there were raised toilets

Requires improvement

Is the service effective?

seats of a different colour to the toilet basins to help identification, there was automatic lighting in the en-suite bathrooms on entry and the door to both bedrooms had been painted a contrasting colour with photo identification on the door so that people were able to find their bedroom easily.

Good

Is the service caring?

Our findings

People who lived at the home and the relative we spoke with told us that staff were kind and respectful. From our discussions, it was clear people and the relative we spoke with held staff in high regard. People's comments included the staff are "Very pleasant" and "Staff are kind". The relative we spoke with said "They have been brilliant helping them settle in. Staff are great".

We observed staff throughout the day supporting people who lived at the home. We saw that all interactions were positive. Staff maintained people's dignity at all times and people looked smartly dressed and well cared for. Staff were observed to be respectful of people's needs and wishes at all times and to support them at their own pace. From our observations it was obvious that people felt comfortable in the company of staff and that staff had a real affection for the people they looked after. This was confirmed by the healthcare professional we spoke with, who said that staff at the home "Genuinely cared" about the people who lived there.

We spoke with the manager, the deputy manager and two care staff about the people they care for. All of the staff spoken with had a good understanding of people's needs and preferences and spoke warmly about the people they cared for. We saw that there were periods throughout the day when staff took the time to sit with people and have a general chat. The mood was homely and relaxed and some people were seen to sit together in companionship throughout the day. People and staff were seen to chat either in passing or in a direct face to face conversation which promoted people's emotional well-being.

Care plans contained evidence that people and their families had been involved in discussions about the care they required. There was evidence that people's ability to self-care and maintain their independence had been discussed and considered in the planning and delivery of care with care plans clearly outlining what people needed help with.

We saw evidence that end of life discussions had taken place with people and their relatives with people's preferences and wishes recorded. This showed us that the home understood and respected the advance decisions made by people in respect of their end of life care. We saw that the manager and staff at the home had completed and achieved accreditation in the NHS Six Steps Programme for end of life care.

We looked at the daily written records that corresponded to the care records we had reviewed. Daily records detailed the support people had received and gave information about the person's general well-being. Daily records showed that people had received care and support in accordance with their needs and wishes.

The home had a service user guide for people to refer to. We looked at the information provided and saw that it was an easy to understand guide to the home, its staff and the services/facilities provided. This showed us that people were given information in relation to their care and the place that they lived.

Regular residents' meetings were undertaken where people were able to express their views and suggestions about the running of the home. We reviewed the minutes of the meetings that took place in October 2015. The minutes of the meetings showed that people were encouraged and enabled to be involved in their care. Where people had made suggestions, there was evidence that these had been acted on. For example, one person had suggested that a particular meal be included on the menu at the home, on the second day of our inspection we saw that this meal was one of the lunchtime choices.

Good

Is the service responsive?

Our findings

People we spoke with confirmed that they could choose how they lived their day to day life. They said that staff were responsive to their needs and respected their choices.

One person told us that they had not agreed with one aspect of their care plan and this had been respected by staff at the home. They went onto tell us how staff had reacted promptly to a change in their health. They said staff made sure they received the support they needed from the district nurse team and swiftly organised adaptive equipment to be put in place to alleviate their discomfort.

The relative we spoke with also provided positive feedback regarding the responsiveness of the service. They told us that one admission, the transition from person's own home to the care home had been seamless. They said that adaptive technology had been sought promptly to meet the person's skin integrity needs, they were happy with the care the person received and the person appeared happy.

The healthcare professional we spoke with told us staff were "Always helpful" and they had "A good partnership" with the manager in meeting people's care needs. They said the manager was proactive in ensuring people received the care they needed and that they "Ring if they need to" to get advice.

During our visit, we observed the culture of the home and the planning and delivery of care to be person centred and holistic. Care records contained sufficient information about people's needs and risks and gave clear information about their preferences and wishes in the delivery of care. We saw evidence people's care was responsive to their changing needs, as care had been reviewed when their needs had changed. People's choices and preferences were also documented for staff to follow.

For example, care records contained a lifestyle choices and preferences form that provided staff with information about the person's preferred daily routines, what the person wanted help with and their dietary preferences. Care records contained person centred information about the person, their life, background and social networks. This enabled staff to relate to and have an understanding of the person they were caring for in order to provide person centred care.

Throughout the day we saw that people's needs were responded to on an individual basis by staff. Staff were observed to support people when required and respect their right to be independent whenever possible. People were spoken to by name and were observed to be treated as 'people first' rather than 'patients' to be cared for. People were happy and relaxed with staff and visitors were welcomed throughout the day.

We saw that people's social and activity interests had been discussed and documented in people's care plans. The provider employed an activities co-ordinator to meet people's social and recreational needs. We saw that an activity timetable was displayed on the noticeboard in the communal corridor. Activities such as chair exercises, dominoes, arts and crafts and scrabble were provided. Seasonal activities were promoted such as Burns Night and on the first day of our inspection, people at the home were enjoying an arts and craft session making Christmas decorations for a local village display.

On the second day of our inspection, we observed a small group of people enjoying chair exercises, people were having a laugh and a joke and actively participating in the activity itself.

People told us they were happy with the activities on offer. One person told us there is "Plenty to do". Another told us that the activities co-ordinator was "Very nice" and that group activities were on regularly. Positive feedback about the activities and the activities co-ordinator was also provided by the relative we spoke with, who said the activities co-ordinator was "Really good and relates to them really well. They get the best out of them".

We reviewed the provider's complaints procedure and related information. We found that there were two procedures in place, one for Lear House and one for its annexe, Elliott House. Both policies gave clear timescale for responding to people's complaints/concerns. The policies lacked clear contact information however, about who people should contact in the event of a complaint.

People we spoke with on the day of our visit had no complaints. The relative we spoke with had no complaints or concerns. Everyone was happy with the care they received and thought highly of the staff. The manager confirmed no complaints had been received.

Good

Is the service well-led?

Our findings

The service was generally well-led. We found that some managerial improvements were needed with regards to the implementation of the mental capacity act 2005 and the practical administration of medication at the home. We spoke to the manager about both of these issues. They demonstrated a positive, proactive approach to addressing these issues and told us they would be looked into and addressed without delay.

We asked people who lived at the home and the relative we spoke with if they thought the service was managed well. People told us it was and the relative we spoke with said "Absolutely". The healthcare professional we spoke with told us it was a "Good home" and the home was well managed.

On the day of our visit, we observed the culture of the home to be open and inclusive. During our visit we found the manager responsive with a compassionate approach to people's care. Staff were observed to work well together and the manager and staff team were observed to have warm, supportive relations in their day to day interactions. This demonstrated good leadership. Staff we spoke with felt supported in the workplace and said the home was well run.

We saw that regular management meetings took place to discuss any issues or suggestions for improvement to the service. The home itself was well maintained, free from hazards with good infection control standards. Everyone we spoke with was positive about the care they received and said they were happy living at the home. Staff we spoke with said the manager was approachable and supportive.

We asked the manager for evidence of the systems in place for monitoring the quality and safety of the service. We were given evidence of a range of suitable systems that were in place to protect people from risk and ensure the service was of good quality.

The manager provided us with a copy of a health and safety audit. A full health and safety audit was completed annually and there was a clear process for reporting and responding to any health and safety issues such as environmental repairs and maintenance. A visual check of the home's environment was also undertaken each day with any repair and maintenance issues noted in the home's diary.

We looked at the manager's accident and incident audits and saw that the manager used this information to identify trends in the type of accidents or incidents occurring so that preventative measures could be put in place, where possible. This information prompted appropriate action to be taken in relation to people's falls. For example, prompt referrals to the falls prevention team were made where people were identified as having persistent falls. Requests for assistive technology were progressed so that people had the equipment they needed to reduce the risk of a potential fall. For example, mobility aids, falls detectors and raised toilet seats.

We asked the manager for evidence that the quality and accuracy of care plan information was checked regularly to ensure that it gave clear and up to date information on people's needs and risks. The manager told us no formal care plan audits were undertaken. They said both themselves and senior staff were responsible for completing care plans and that staff alerted the manager when any changes were required. The care plans we looked at during our inspection were of a good quality.

There was a system in place for ensuring medication was appropriately checked. Staff undertook a count of the medication in the trolley after each medication round and a monthly medication audit checked that stock levels matched administration records. We did a sample check of stock levels during our visit. We found the balance of medication matched what had been administered to people who lived at the home.

We asked the manager if any infection control audits were undertaken. They provided us with an organisational infection control audit that looked at all areas of the home, its equipment and policies. We saw from the audit records that this audit was reviewed monthly and the home had scored highly in all aspect of infection control. On the day of our visit, the home was clean, had sufficient supplies of personal, protective equipment and had no offensive smells.

We saw that views on the quality of the service provided was regularly sought from people who lived at the home and their relatives through the use of a satisfaction

Good

Is the service well-led?

questionnaire. We saw from the sample of questionnaires we were given that the results were positive. An analysis of the questionnaires had not been undertaken but assurances were given by the Chief Executive that any issues identified had been addressed. An analysis of these questionnaires however would enable the provider to identify trends and the impact of any potential improvements over consecutive time periods.

Overall, we found the home to be well organised with a person centred, flexible approach to people's care.

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 Medicines at the home were not always administered in a safe way. Regulation 12(2)(g) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's ability to consent to decisions about their care had not been fully considered in the planning or delivery of care in accordance with the Mental Capacity Act 2005. Regulation 11(1) of the Health and Social Care Act 2014 Regulations.