CareQuality Commission

GCH (West Drayton) Ltd

Drayton Village Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection was carried out on 29 and 30 January 2015 and the first day was unannounced. During the last inspection on 5 June 2014 the provider was meeting the regulations we checked.

Drayton Village Care Centre provides accommodation for people requiring nursing or personal care for up to 59 older people. The service was purpose built and was registered in December 2013. The service provides accommodation in single rooms with en suite facilities. There are communal dining and sitting rooms on each floor. At the time of the inspection there were 43 people using the service.

The service is required to have a registered manager in post, and the registered manager has been at the service since July 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although some aspects of medicines management were safe, some medicine records were incomplete and the quality assurance system for medicines was not effective.

Summary of findings

Staff understood safeguarding and whistleblowing procedures and knew to report concerns. Some staff required training in safeguarding to understand the different types of abuse.

Staff were able to meet people's individual care and support needs effectively, understanding and respecting the different needs of the people using the service.

Staff we spoke with and records we saw confirmed recruitment procedures were being followed. Staff training and supervision was not always up to date and work was in progress to address this.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS is where the provider must ensure that people's freedom is not unduly restricted. However, it was not always evident who had been involved in making decisions in respect of whether people wished to be resuscitated, and this needed to be addressed.

People said they felt safe at the service, were happy with the care they received and said staff treated them with dignity and respect. We observed staff supporting people in a gentle, professional and understanding way, promoting people's independence and showing them respect.

People had a choice of meals and staff were available to provide support and assistance whilst respecting people's right to independence. Staff monitored people's conditions and referred them for input from healthcare professionals when they needed it.

People and their relatives were happy with the care provided and were given the opportunity to be involved with their care plan, so their wishes could be identified and met.

Systems were in place to monitor the quality of the service, however these were not always robust and had not identified the shortfalls we found during the inspection. People and relatives felt able to express any concerns, so these could be addressed.

You can see what action we 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

Some aspects of the service were not safe.

Although some aspects of medicines management were safe, such as the review, ordering and storage of medicines, some medicines records were incomplete and the quality assurance system for medicines was not effective. This meant that we could not be sure that people always received their medicines on time and as prescribed.

People said they felt safe living at the service. Staff were aware of safeguarding and whistleblowing procedures and to report any concerns. Not all staff had completed safeguarding training and this was being addressed.

Assessments were in place for identified areas of risk. These were reviewed monthly, so the information was kept up to date. Equipment was being serviced and maintained at the required intervals.

Staff recruitment procedures were in place and being followed. There were enough staff to meet people's needs and action was taken to cover staff absences.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Staff had not always received training and supervision to support them and to keep their skills and knowledge up to date.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted.

It was not clear if people's views had been sought regarding resuscitation and action was needed to ensure their views were ascertained and appropriately recorded.

People had a choice of meals and received the support and assistance they needed from staff with eating and drinking, so their dietary needs could be met.

People's healthcare needs were monitored and people were referred to the GP and other healthcare professionals when input was required.

The environment was good and provided people with good quality accommodation throughout.

Is the service caring?

Good

The service was caring. People and their relatives spoke highly about the excellent care people received.

Summary of findings

Staff demonstrated a good understanding of people's individual needs and how to meet these. Treating people with dignity and respecting their wishes was at the centre of all the care and support staff provided.

People and their relatives were regularly involved with making decisions about their care so their wishes could be discussed and included.

Is the service responsive?
The service was responsive.

Good

People and where appropriate their relatives had been consulted about their care needs and the information had been recorded in the care plans, so staff knew the care each person required. Records were reviewed monthly and people were involved with these, so their wishes were known and could be respected.

A complaints procedure was displayed and people and their relatives said they would raise any concerns so these could be addressed.

Is the service well-led?
Some aspects of the service were not well led. Systems were in place to monitor the quality of the service, however these were not always robust as they had not identified the shortfalls found at the time of inspection.

Requires improvement

People and their relatives were consulted about aspects of the service so their opinions could be used to improve the service.

Good practice guidance was used to inform protocols and practices, so staff had relevant information to keep up to date with best practice.

Accidents and incidents were monitored and where possible action was taken to minimise the risk of recurrence.

Care Quality Commission

Drayton Village Care Centre

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.

The inspection was carried out on 29 and 30 January 2015 and the first day of the inspection was unannounced.

The inspection team consisted of three inspectors, one of whom was a pharmacist inspector. Before the inspection we reviewed the information we held about the service, including notifications and other communications we had received about the service.

During the inspection we viewed a variety of records including four people's care records and four people's daily monitoring records, servicing and maintenance records for equipment and the premises, twenty nine medicines administration record charts, five staff files, a selection of audit reports and a sample of policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the mealtime experience for people on the ground floor and interaction between people using the service and staff on both floors.

We spoke with nineteen people using the service, thirteen relatives and met with four more relatives at a relative's meeting, the registered manager, the deputy manager, three registered nurses, six care staff, the activities coordinator and a laundry assistant. We also spoke with the regional manager, the director for care, quality and compliance and a member of the local authority monitoring team.

Requires improvement

Is the service safe?

Our findings

Some medicines records were incomplete. We looked at medicines records for 29 people and found some gaps in the recording of administration for 13 of these people. The deputy manager told us that as the doses of these medicines were missing from medicines containers, and from discussions with nursing staff, they were confident that these doses had been administered but that nurses did not always remember to complete the record after administering medicines. However as the records of administration had not been completed, and some of the gaps were for eye drops and liquid medicines, we could not be sure that these doses of medicines had been administered. There were also gaps in recording on other medicines records, such as when care staff applied prescribed creams. The exact times that medicines were administered were not recorded, as medicines records stated, “breakfast” “lunchtime” “evening” or “night” so we could not assess whether medicines were always administered at the correct times. Although we did not find any evidence of medicines errors, incomplete medicines records indicate that there is a possibility that an error may have occurred, and there is therefore a risk of people not receiving their medicines as prescribed.

The quality assurance system for medicines was not effective. On 04 December 2014, after an inspection by the local authority inspection team, issues were identified with the recording of medicines. In response to this, the provider submitted an action plan, which said that they would carry out weekly medicines audits starting on 09 December 2014. We saw that although audits had been taking place, these had not been carried out weekly and the issues with the recording of medicines that had been identified in December 2014 had not yet been rectified.

The above paragraphs demonstrate a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

All medicines, including controlled drugs, were stored securely and at the correct temperatures. Supplies of controlled drugs and medicines not contained in blistered packs were counted regularly, to check for accurate administration. Appropriate arrangements were in place to manage controlled drugs, to order repeat prescriptions for people and to safely dispose of unwanted medicines.

One person with dementia had been experiencing agitation. We saw that the home had sought advice from a mental health specialist unit, and this person had been prescribed sedating medicines for use only when needed. We saw that these had not been used excessively or inappropriately. During handover we heard the night staff report on people who had woken in the night and how people had been settled by making them a cup of tea and having a short chat avoiding the unnecessary use of sedating medicines. People’s medicines were reviewed regularly by the GP. There was also input from the Clinical Commissioning Group pharmacist to carry out medicines reviews for people to ensure effective prescribing.

The provider took action immediately during our inspection to address some of the issues with records that we identified, and the registered manager wrote to us on 05 February 2015 to confirm that they had taken steps to address the remainder of the issues, such as implementing weekly medicines audits to check for gaps in recording, holding meetings with nurses to remind them of their professional responsibility for the recording of medicines, and plans to carry out medicines competency assessments for nurses by the end of February 2015.

People confirmed they felt safe living at the service. We spoke with staff about their understanding of safeguarding. Staff said they would report any concerns to their line manager and the majority also knew to report concerns to the local authority or CQC if the service did not respond if they raised concerns. Staff pointed out the location of the company’s whistleblowing policy, copies of which were displayed on each floor. Half of the staff had not yet received training in safeguarding and were not able to identify all the different types of abuse. The majority of the staff were able to describe signs of abuse and explained the actions they would take if they had concerns, including recording and reporting any incidents. The interactions we observed between people living at the service and the staff supporting them demonstrated that staff protected people's dignity and treated them with respect. Some staff specifically mentioned the risk of psychological harm that could be caused if people were not treated in this way. The registered manager was aware of staff that had not received safeguarding training and showed us a training plan that included safeguarding training sessions for February 2015.

Requires improvement

Is the service safe?

People's care records contained information about people's risks, setting out what staff needed to do to ensure that people living at home and staff were safe. For example, we saw instructions for supporting a person who had an infection were clearly set out in their care record and we saw staff adhering to these instructions when supporting the person. Where people were at risk of developing pressure sores, we saw instructions for staff were set out concerning equipment, skin care, frequency of repositioning people and general and observational checks. We viewed the records kept in the rooms for people living at the home which recorded the required checks were being carried out. Risks were routinely reviewed as part of the monthly review of care records. However we did notice that the location of information within people's care files about risks was inconsistent and recommended this be addressed so all risk assessments were located in the bespoke section of the care records, so staff knew where to find them and minimise any risks being overlooked.

We saw that accidents were recorded in people's care records. For example, we saw a person with a bruise. We checked the person's file and saw that a record of an incident had been completed which explained how the person had received the injury. We noted in another care record that previous incidents or accidents had been clearly recorded. The fire risk assessment for the premises had been updated in January 2015 and staff took part in regular fire drills. Daily checks of escape routes and emergency lights, weekly checks of the fire alarm system and monthly building fire management checks were carried out and recorded. The registered manager was aware of the importance of good fire safety within the service to protect the people living, working and visiting the premises. We viewed a sample of equipment servicing and maintenance records. These showed that equipment including portable electrical appliances, lifts, baths and hoists, fire alarm and emergency lighting systems had been checked and maintained at the required intervals, to ensure these were safe. Weekly in house checks such as water temperatures and flushing of out of use water outlets were up to date. A monthly safety check of all rooms and sections of the building was carried out and recorded. This showed the service was being maintained to provide people with a safe environment to live in.

The staff records we viewed showed employment checks were being carried out to ensure only suitable staff were employed at the service. Application forms and health questionnaires had been completed and gaps in employment histories explained. Checks including references, proof of identity, right to work in the UK and criminal record checks had been carried out. We asked six staff about how they were recruited for their posts. Staff told us they had heard of the position either by word-of-mouth or in local newspapers. They said that they had filled in application forms as part of the recruitment procedure setting out their previous background and experience. They said that they had attended an interview and the provider had taken up the two references they were required to provide. Staff confirmed that they had not been allowed to start work until their criminal record checks had been received.

At the time of inspection there were sufficient numbers of staff on duty to meet people's needs. Some people commented that at times the staff seemed to have too much to do and CQC had received some concerns that on occasion there had been one registered nurse on duty for 43 people. The deputy manager explained they had been building up the staffing alongside the numbers of people being admitted to the service and felt they had maintained appropriate staffing levels to meet people's needs. We viewed the staffing roster for January 2015. Where staff were on leave or off sick action had been taken to provide cover, including using agency staff when required. We spoke with the registered manager who told us there were currently 17 people who required nursing care and 26 who required personal care only. The service did not have designated floors or units for providing nursing or personal care and were deploying registered nurses on both floors, rather than having senior care staff trained up to manage the care of people who required personal care only. Any nursing input for people who required personal care on a day to day basis should be provided by the community nursing team. We discussed these issues with the registered manager and the director for care, quality and compliance for the service and they said this would be reviewed so people received the appropriate level of care and nursing input to meet their needs.

Requires improvement

Is the service effective?

Our findings

We spoke to staff about their induction training and additional training they had received at home. We were told that the induction programme was supposed to last five days. Two of the registered nurses we spoke with told us they had only two days induction before then being the nurse in charge. One of the care staff said they had two days training whilst another reported that they had had three days training plus two days shadowing another member of staff before they started to work independently. We asked staff about the training they had received during and since induction. Staff mentioned courses on infection control, mental health and fire training. Several of the staff we spoke to said the training at the service was minimal and that they were not given access to certificates for these courses. The registered manager had already identified training shortfalls and showed us training plans for January, February and March 2015. These included moving and handling, medicines management, control of substances hazardous to health and safeguarding. The registered manager said he was planning more training to bring staff knowledge and skills up to date and was working with a training provider to identify and book courses relevant to staff needs.

We asked staff about their supervision and appraisals. Some staff said that they had meetings with their line managers every six weeks or so. One member of staff reported that these meetings had been very useful and offered an opportunity to discuss any difficulties they were having. Others said they had not had any supervision meetings. Annual appraisals had not yet been carried out because the home was new and most staff had not been there for more than a year. We viewed the supervision record and for the care staff no entries had been recorded since August 2014, although some staff stated they had received supervision more recently. The registered manager said he had commenced supervision sessions with staff and we saw this had been recorded for staff including the administrator, activities coordinator, housekeeper, maintenance person and deputy manager. He explained there were staff who had not received supervision due to changes in the nursing staff, who were the supervisors for the care staff, but this was being addressed as new nurses were being employed. He said annual appraisals would be arranged for staff near the anniversary of their year working at the service.

This is a breach of Regulation 23 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). This is where the provider must ensure that people's freedom is not unduly restricted. Where restrictions have been put in place for a person's safety or if it has been deemed in their best interests, then there must be evidence that the person, their representatives and professionals involved in their lives have all agreed on the least restrictive way to support the person. Policies and procedures in relation to the Mental Capacity Act 2005 (MCA) and DoLS were in place and the registered manager understood the criteria and process for making a DoLS application. Some of the staff we spoke with had received training on aspects of the Mental Capacity Act and were aware of the need for people to provide informed consent to their care unless formally assessed as not able to consent. Where appropriate, people had been assessed to determine if they had capacity to make decisions for themselves. We saw in the care records DoLs applications had been made to the local authority when it was considered necessary to restrict someone's choices. A relative of someone who had been assessed told us. "[Relative] has a DoLs' because of her constantly wanting to go home. We have signed this. They also assessed her need for bed rails and we have signed our agreement of this."

Codes for the keypads on doors were displayed for people who were able to go out independently. We saw one person go out to the shop next door and another person who used an electric wheelchair told us that they were able to go out to the shops independently. People with capacity had signed consents in their files agreeing to the contents of their care plans and to the taking of photographs.

We noted that do not attempt resuscitation forms (DNARs) were not filled out correctly in the files we looked at. For example, in one person's file it was clear that they had capacity to decide if they did not want to be resuscitated but the form had not been signed by a GP. This meant it was invalid. In another person's file it was not clear what decision had been made about their preferences and what the instructions for medical staff were. Other DNAR forms we looked at did not always state who had been involved, other than the GP, in making a decision to not provide resuscitation for people who were not able to express a

Is the service effective?

view. The registered manager said few people had made their wishes known regarding this topic, however this was not reflected in the documentation we viewed and this needed to be addressed.

This paragraph demonstrates a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

The cook told us about people who required special diets. For example, we were told about people who needed their food pureed whilst others needed it at a 'forkable mash' consistency. We saw the menu choice forms that had been completed with people's meal options. Most people confirmed they were offered a choice of meals and we saw new menus that had been designed following consultation with people and their families about the meal provision at the service. From 8.30am we saw people in the dining room and in their rooms being offered a choice of porridge or cereal. Staff asked people if they wanted hot milk or cold and if they wanted toast. We asked if a cooked breakfast was an option. Staff said that it was and they only had to phone up to kitchen to order this if a person wanted one. We did not hear or see anyone opting for a cooked breakfast during our inspection.

Drinks including tea and coffee or juice were served at various points throughout the day and were available at all times. People confirmed they were encouraged to drink fluids and we saw staff doing this during the inspection. One person said, "Staff keep an eye on me, for example if my water jug goes down they come in and fill it up. They think I need to drink more and keep an eye on my water for me." We observed people having lunch and saw carers asked people what they wanted to eat and that there was a choice of main dishes. Staff supported people in a careful and unhurried way and there were enough staff to provide the support and assistance people required. The kitchen staff were involved with the serving of meals and also engaged with people. We heard the chef say, "I made the apple pie – it's not from a shop" when showing people food to see if they wanted apple pie or the alternative that day of ice cream. Two people thanked the chef and those supporting them to eat saying "thank you" and "it was lovely."

We saw that detailed information was kept in relation to monitoring people's health. People's weight was recorded monthly along with an assessment of their dependency level, nutritional intake and their risk of pressure sores. In all the files we viewed we saw these records were up to date. Where people had wounds, photographic records had been made and people had been referred to the tissue viability specialist nurse for input. Input from healthcare professionals was accessed as required to meet people's needs. During our visit we saw an optician arrived to fit someone with spectacles and people's records indicated medical appointments were arranged when required. Most of the relatives and the people we spoke to said the home was very quick to arrange medical assistance when it was needed. For example one person said, "If you need to see a doctor they are very quick." And a relative said, "They communicate well with us about the appointments [relative] needs at the hospital." Only one person mentioned any delay. They said "I'm not sure how quickly the GP reacts. [Relative] has had wax in their ears for a while and is still waiting to see the doctor." The manager explained there were four GPs providing medical services and people were referred for visits when necessary.

We saw people had been referred to other professionals where required including referrals to psychologists. A relative said the service had arranged for their relative to be seen by a psychologist to help diagnose the cause of their agitated state. They told us, "They had a psychiatric person see her because she wasn't settling. He suggested things like a storybook. They doubt that she will stop wanting to come home. It's about how well staff can calm her and they seem to be doing better." However we noted in another person's file a report from a psychologist about a person who had been referred due to depression. Recommendations made concerning the provision of particular literature and art equipment had not been provided. We spoke to the activities coordinator about this. They were aware of the person's needs but had not been able at that time to provide the particular equipment and books that the psychologist had recommended. This showed the service was proactive in seeking advice and support on how to best provide care to people, however recommendations made were not always acted on promptly.

People had access to plenty of space to either be alone or to be with others. Each floor had a spacious lounge and a separate large airy dining area which people were able to use throughout the day. Throughout the service we saw people chatting with their relatives in the dining room or in people's individual rooms. People were able to personalise

Requires improvement

Is the service effective?

their rooms and one relative showed us they had brought things to make the room homely. Corridor walls had pictures on of famous people, landmarks and places of interest, and there was a homely atmosphere throughout.

Good

Is the service caring?

Our findings

People and their relatives were positive about the care provided at the service. Comments from relatives included, "Staff are good with the people here. They squat down when they're speaking to people rather than talking down to them. They are always kind and well mannered." "He always looks clean and tidy when I come in. It seems a really good place and I've never seen anything untoward." "[Relative] chooses what she wants to wear and likes to wear clothes that match. They know what she likes to eat and there is a choice every day." One person said, "Today I got up a bit later because last night the nurse said my sugar levels were high and so staff checked me during the night. This woke me up a lot so I'm tired today and felt like a lie in." another said, "Staff are very, very good – I would say so if not."

The interactions between staff and people we observed showed people liked the staff and felt safe and comfortable with them. We saw staff chatted with people throughout the day, at mealtimes and during the afternoons while they were sitting in the lounge. We noted that some of the day staff arrived early for their shift, bringing in papers for people and going around and saying hello to those who were up. We saw people often thanked staff for doing something for them which indicated they appreciated the people working there. People told us the staff were very good, kind and treated them very well. For example one said, "The staff are very nice and helpful and caring. When you are awake at night they ask why and try to put things right for example they're willing to make me a cup of tea and chat a little and they asked me if I'm in pain." We saw a person wander out of their room without slippers and soon after noted a staff member had found the person's slippers and assisted them to put them on. Call bells were answered within a short period of time, so people were not kept waiting for staff to attend to them.

We saw staff taking the time to ask people about their care before doing something. At breakfast people were asked about their choice of cereal and we heard somebody being asked whether they wanted a hot breakfast that day. We noted staff asked if people would like help before assisting them and one staff member said, "Can I help you with that?" Staff were observant of the needs of people whose speech was limited, so they could understand what help and support they required. Staff were sensitive to the needs of the people they were supporting. During the lunchtime meal one care worker observed the person they were assisting appeared to want to feed themselves, so they supported the person to hold the utensils to do this. In another instance a member of staff noted a person was picking up the remains of the food on their plate and checked to see if the person wanted an additional portion. This showed staff supported people in being as independent as possible and used their observations of people's body language to anticipate their wishes. We observed mealtimes on both floors and staff chatted to people, provided the support they needed and there was a good atmosphere throughout the service.

We heard staff ask people where they wanted to be during the day before moving them from one area of the service to another. They explained to people what activities were available so they could choose whether they wanted to be involved. Relatives we spoke to said people's choices were optimised. For example, one said, "It couldn't be better. Lovely food. [Relative] makes her own decisions. She has been assessed as having full capacity and is able to make decisions for herself. They help her getting up when she wants to get up and she can eat what she likes. One day she had two breakfasts because she wanted it again." Another relative said of the staff, "they are absolutely great and getting better and better." People with religious or cultural needs were happy with the care they received and were confident their wishes and needs were being met. One person said, "I like the food. They would cook more Indian food if I asked."

Staff understood the need to respect people's privacy. One member of staff described how they ensured doors were closed when personal care was given and that this was always carried out in people's own rooms. We saw staff taking care to close doors before supporting people with their personal care as well as asking for permission to support somebody and explaining what they were doing. We saw staff included people in conversations about them and the service and supported them to maintain their independence. Relatives were free to come and go as they wished and had access to door codes. We saw the codes for the doors were available to people who were able to go out independently. While we were there we saw one person go out to the shop next door and another person who used an electric wheelchair told us that they were able to go out to the shops independently.

Good

Is the service responsive?

Our findings

People and their relatives felt staff responded to their needs. Comments we received from relatives included, "I get good information about how [relative] is doing. For example they could tell me how her skin is improving and they got a new mattress better suited to her needs. The staff are excellent here. We have every opportunity to put our point of view across." "We have residents meetings every six weeks or so" and "The only thing is the laundry. It's hard to get the staff to sort it sometimes. But they don't mind me pointing it out and say they like to know so that they can address these things."

Relatives said they had been able to visit the service, unannounced if they so wished, to view it for their family member. We spoke to a number of relatives of people who were not able to express their needs and make decisions for themselves. Relatives told us their family member had been assessed before coming to the home and they had been involved in drawing up their family members' care plan and were involved in care plan reviews. For example one relative told us, "I was involved with drawing up [relatives] care plan and I've been through it with the deputy manager since then." The care records we viewed had people's needs and preferences recorded in detail. For example one person's care plan described how they like their food to be presented as well as what they actually liked to eat. Information was provided about people's preferred bedtime, when they liked to get up in the morning and whether they preferred their doors left open, closed or just ajar. We saw people got up and went to bed when they chose and preferences about bedroom doors were respected. One person told us, "I get up at 6 o'clock. I prefer to get up early and have a shower." Where a person needed to have their position changed, be regularly checked, or have their food and fluid intake monitored, we saw signed and dated records showing that these checks had been carried out and the information was also used to review people's care.

We saw some files were very detailed whilst other files contained limited information about the person and their preferences. We asked staff about this and they explained that this could depend on how long a person had been at the service and how much was known about them. They said the information might be limited about people who only came in for short periods of respite care, as they had not been able to build up a full picture of the person yet.

The weekly activity sheet was displayed in areas within the service. A standard programme was offered with an activity each day, Sunday to Thursday. This included reminiscence, pampering and music sessions. We saw three staff engage with people during a session of hymn singing. One person had a quiz book to do. Later in the day bingo was offered by the activities worker with support from care staff. People said they enjoyed the activities, and staff gently encouraged people to join in. One person said, "I'm going to bingo. Staff suggested it because I was a bit down this morning." We spoke with the activities coordinator who explained her colleague usually covered Friday and Saturday, to provide activities 7 days per week. We asked about meeting people's religious and cultural needs and she told us she was in contact with the local Christian churches and would arrange input for people of other religions if they wanted this. She told us she obtained information from people's care records about their hobbies and interests and also from speaking with people and their relatives. Photographs were displayed of events and activities that had taken place, for example, a Christmas celebration party. The activities file contained records of other outings and events, for example, entertainers for a World War Two themed afternoon, trips out to local garden centres, places of interest and the summer barbeque at the service for people and their visitors.

We spoke with nine people or who lived at the home or their relatives who were able to tell us about how they would raise any concerns they had about the way they were treated. Most said that they did feel able to do this by speaking directly to the registered manager. One person said, "if I was not happy I would say so." We noted that one person who expressed concerns about their care was in regular dialogue with the manager about this. People or their relatives we asked were not aware of a formal policy or procedure for raising concerns. A copy of the complaints procedure was on display in the foyer area and the registered manager said copies were also contained in the information emailed out to people or their relatives to inform them about the service. At the relatives meeting people were encouraged to bring any issues to the attention of the registered manager so they could be addressed. The registered manager said he would raise the

Good

Is the service responsive?

awareness of people and their relatives about the complaints procedure. We viewed the complaints file and saw where concerns had been raised these had been investigated and responded to in a timely way. The registered manager said he welcomed comments from people and their relatives so that any issues could be addressed. We saw a comments box in the staff room, encouraging staff to make suggestions or raise any issues they might have.

Requires improvement

Is the service well-led?

Our findings

The registered manager was a qualified social worker with many years of experience in adult social care and child care. He had been in post since July 2014 and registered with CQC since October 2014. We attended a relatives meeting and the manager went through the minutes of the previous meeting and discussed the actions that had been taken. The manager was clear in his communication, encouraged relatives to express themselves and listened to their points of view. He gave relatives the opportunity to discuss any matters they wished to and spoke about new ideas being introduced at the service, for example, new menus which had were based on discussions that had taken place with people so they had input into what was on the new menus. The meeting was also attended by the deputy manager, who was a registered nurse and the activities coordinator. A variety of topics were discussed in the meeting including care, activities, input from healthcare professionals and exploring the possibilities for relatives to attend training, for example, in dementia care, to better understand the needs of their family members. We also observed the registered manager communicating effectively with people using the service and staff throughout our inspection.

The service had an auditing system in place. This included a monthly weight check, which recorded input from healthcare professionals such as the speech and language therapist, so it was identified that people required specialist input. An accident and incident analysis was done each month to look for trends and identify any areas for improvement. An infection control audit had been completed in January 2015 and identified pedal bins for replacement. The registered manager confirmed this had been actioned. A quarterly health and safety audit had been completed in October 2014 and January 2015. The second audit identified an improvement from 81% to 97% and identified the action plan from the first audit had been completed. This demonstrated the service took appropriate action to address identified shortfalls. The local authority monitoring team had carried out a visit in December 2014 and we found the majority of issues they had identified had been addressed. However, shortfalls identified during this inspection with medicines management, completion of DNAR documents and staff training meant the monitoring processes were not all robust.

The registered manager said satisfaction surveys had recently been sent out as the service had been open for a year and this was the first survey, so the results would be collated once received.

The provider had policies and procedures and these were based on good practice guidance and relevant legislation. For example, health and safety policies included reference to the Health and Safety at Work Act 1974 and the Occupiers Liability Acts 1957 and 1984. This meant the policies and procedures were informed by appropriate legislation and guidance.

The registered manager told us he was a member of a Care Home discussion group on a professionals networking site, on which current issues related to care services were discussed, for example, funding and dementia care. He said he followed recognised guidance including the National Institute for Health and Clinical Excellence guidance, and had studied this for topics including dignity, decision making, medicines and dementia care. He demonstrated a good knowledge of the care people with complex needs required. The deputy manager was responsible for overseeing the nursing input people needed for their care and treatment, to ensure their needs were being appropriately met. The registered manager and deputy manager were approachable and receptive to the feedback we provided. Where possible they addressed areas at the time of inspection and understood the importance of addressing any issues promptly.

We spoke with the director for care, quality and compliance for the provider, who had a degree in dementia studies. She explained she was setting up a working party in February 2015 to develop an accredited course in dementia care for all the services to achieve, with a plan to roll this out to all the services by June 2015. The service had been offering people rehabilitation, with input from specialists such as physiotherapists, occupational therapists and psychologists. At the time of inspection the provider was in the process of ensuring this section of the care provision was appropriately registered with CQC, before opening a purpose built unit on the second floor. The registered manager was clear that the categories of people to whom services were offered needed to be clarified. This was so people's needs could continue to be met and the appropriate healthcare professionals, for example, the community nurses, be involved in providing treatment where appropriate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Effective arrangements were not in place for the recording and auditing of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure staff received appropriate training and supervision to enable them to deliver care and treatment safety and to an appropriate standard. Regulation 23(1)(a)