Springfield Care Services Limited

Springfield

Inspection report

1 Lowther Avenue
Garforth
Leeds
West Yorkshire
LS25 1EP
Tel: 0113 286 3415
Website: www.springfieldgroupcarehomes.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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We inspected the service on 19 and 20 March 2015. The visit was unannounced. Our last inspection took place on 27 May 2014 and, at that time; we found the service was not meeting the regulations relating to care and welfare of people who used the service and not meeting nutritional needs. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to ensure they were meeting the regulations. On this visit we checked and found improvements had been made in the required areas.

Springfield provides accommodation and personal care for up to 71 people. The home is located in a residential area of Garforth on the outskirts of Leeds. All bedrooms are single occupancy and have en-suite toilet facilities. Communal lounges, dining rooms and bathing facilities are provided.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

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 looked at the arrangements in place for the storage, administration, ordering and disposal of medicines and found these to be safe. Medicines were administered to people by trained care staff.

People received sufficient amounts to eat and drink. We found the dining experience throughout the home was not consistently good.

Deployment of staff within the home was not arranged according to the dependency of people using the service.

The premises of the home were well maintained and in a good state of repair. Regular environmental checks were carried out by the registered manager. We looked in people's bedrooms and found people had personalised their rooms with ornaments and photographs.

Robust recruitment processes were in place which ensured staff were suitable to work with vulnerable adults.

The local authority had limited the amount of deprivation of liberty applications they would accept from the home at any one time however, the registered manager had not taken steps to identify people who were potentially at risk of having their liberty deprived.

A programme of activities was in place with staff employed to deliver this. People using the service told us this was not delivered consistently throughout the home.

Staff received regular supervision and annual appraisals. This gave staff the opportunity to discuss their training needs and requirements.

People using the service and their relative had opportunity to give their views and opinions on the service provision. There were regular resident and relative meetings and satisfaction surveys were also distributed to people using the service on an annual basis.

Staff demonstrated a good understanding of how to protect vulnerable adults. They told us they had attended safeguarding training and were aware of the policies in place regarding reporting concerns.

Care plans were person centred and individually tailored to meet people's needs.

We found a number of issues which the provider had failed to identify through an effective system of quality assurance.

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 always safe

We found the home had arrangements in place which ensured people's medicines were managed safely.

People were cared for in a clean environment with suitable equipment in place which reduced the likelihood of the spread of infection.

There were sufficient numbers of staff on duty to ensure people's safety. However, people's dependency was not considered in the deployment of staff within the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional needs were met however the dining experience for people using the service was not consistent throughout the home.

The service was meeting the requirements of the Mental Capacity Act 2005. Our observations of the environment and people's care plans that were not subject to DoLS suggested the provider utilised a number of methods which may constitute a deprivation of liberty.

People's health care needs were being met in the home by visits from their local GP and chiropodist.

Is the service caring?

Requires Improvement

The service was not always caring.

Throughout our inspection we observed people being treated with dignity and respect.

All of the staff we observed offering people support demonstrated having caring attitudes.

There were missed opportunities by staff to engage with people on a one to one basis.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The home employed staff for the purpose of arranging and facilitating a programme of activities. We were told these were not delivered consistently throughout the home.

Care and support plans were written with a person centred approach and ensured staff had clear guidance on how to meet people's needs.

Summary of findings

Complaints and concerns were dealt with appropriately and as per the policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post. Staff we spoke with told us they felt the management in place at the home were approachable and supportive.

The home had mechanisms in place which allowed people using the service and their relatives to provide feedback on the service provision.

The provider had a quality assurance system in place to monitor the service provision. However, we found several issues relating to care records, environment, deployment of staff and activities which the quality assurance system had failed to identify.

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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 19 March 2015 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor with a background in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector returned to the home for the second day on 20 March 2015. This visit was announced.

At the time of our inspection there were 66 people living at the home. During our visit we spoke with six people who used the service, six members of staff, the deputy manager and the registered manager. We spent some time looking at documents and records related to people's care and the management of the service. We looked at people's care records. We also spent time observing care in the communal areas of the home on two of the four units which included lounge and dining room areas to help us understand the experience of people living at the home. We looked at all areas of the home including the kitchen, people's bedrooms and communal bathrooms.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and also contacted the local authority safeguarding team.

Requires Improvement

Is the service safe?

Our findings

The home was clean and tidy and free from malodours. We looked at various areas of the home including the lounges, dining rooms and bathrooms. We also with people's agreement looked at some people's bedrooms which were clean, tidy and personalised. We found the home was maintained well and looked in a good state of repair. We looked at maintenance records and saw all necessary checks had been carried out within timescales recommended in guidance and legislation. We experienced some very dull areas within the home where natural sunlight was very limited. Even with lights switched on, some areas remained dull and could pose risks to falls and trips of service users.

We spoke to two service users and three staff regarding the safety measures in place within the home. We asked if people felt safe. One service user told us "We have some wanderers here which scares me at night in case they come into my room." Another service user told us they thought the home was a very safe place to live. All of the staff we spoke with told us they felt the home had enough staff on duty to keep people safe and meet their needs.

We saw areas of the home had key pad protected doors in place. We observed one service user opening an inner door by using the key code. The service user told us the staff gave them the code so they could go to their room without relying on the carers.

An infection control policy was in place and staff were aware of, and followed its guidance. We observed most staff following safe routines using protective equipment such as gloves, aprons and hand gel. However, we did notice one member of domestic staff wearing the same pair of gloves to clean different people's bedrooms. This meant there was a risk of cross infection. We highlighted this to the manager who spoke with the person immediately.

A member of staff we spoke with said, "The cleaning is good, we have domestic staff but if we see any spillages we won't leave it." We witnessed a fluid spill on the floor of the ground floor dining room. We brought it to the attention of staff who immediately left to gather the equipment to clear up the spillage. However, a 'wet surface' sign had to be put near the spillage by the inspector as service users were mobile around that area of the dining room and were at risk of slipping.

Staff we spoke with told us personal protective equipment (PPE) was available. We saw an ample supply of gloves of various sizes in the store room and around the home. All the bathrooms and toilets contained notices regarding hand washing procedures and had liquid soap and paper towels available. These measures promoted a clean environment for people and reduced the risk of the spread of infection.

During the afternoon we noticed staff on some units had been to collect sandwiches for tea which was due to be served, these were left in the kitchen area of each unit, whilst they were covered in cling film they were left on a work top and not in the fridge for some considerable time and would have been done so for at least two hours. We asked staff about this and they told us they would collect sandwiches for tea and would normally leave them on the worktop until teatime. We spoke with the deputy manager about this and they said the sandwiches should have been in the fridge, she instructed staff to throw away the sandwiches and ask the kitchen to make fresh sandwiches.

We found there was a robust recruitment policy in place. Staff we spoke with told us they had filled in an application form, attended an interview and were unable to begin employment until their Disclosure and Barring Service (DBS) checks and references had been returned. The DBS is a national agency that holds information about criminal records. We looked at four staff personnel files which showed detail of the person's application, interview and references which had been sought. This showed that staff was being properly checked to make sure they were suitable to work with vulnerable adults.

We asked staff about the home's safeguarding procedures. They told us the procedures were very clear and they would without a doubt use them if they thought there was anyone at risk of abuse. One member of staff told us they had done some 'reflection' on safeguarding a few weeks ago. Another member of said, "I have never seen anyone being unkind or unpleasant, but if I did I would report it to the manager." We spoke to three staff who all told us they enjoyed working at Springfield. They felt that it was well staffed and that they all understood and expected that part of their role was to ensure the safety of all the service users. All three staff also

Is the service safe?

showed confidence in the process to follow should they suspect actual/potential harm to a service user. Staff training records showed all of the staff who worked at the home had received training in safeguarding adults.

We looked in people's care records and saw where risks had been identified for the person, there were risks assessments in place to ensure these risks were managed. For example, care records showed assessments were carried out in relation to mobility, nutrition and medication. These identified hazards that people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm.

We looked at the arrangements in place for the storage, administration, ordering and disposal of medicines and found these to be safe. Medicines were administered to people by trained care staff. No person at the home had been found to have the capacity to self-medicate.

Upon entering the home we saw a clear notice requiring staff and visitors not to disturb care staff wearing a red tabard which denoted they were administering medicines. We saw during both morning and lunchtime medicine rounds the care worker was wearing the red tabard. This demonstrated the manager was taking action to ensure the risks associated with the administration of medicines were being mitigated.

Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found that medicine trolleys and storage cupboards were secure, clean and well organised. We saw that the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure medicines were being stored at the required temperatures. Our scrutiny of the medicines policy showed fridge temperatures should be recorded twice a day whilst in practice they were recorded once. The manager told us they would review the procedure.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

We saw evidence people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on MAR sheets were signed by care staff.

We looked at prescription sheets and care records to ascertain the frequency of use of, as necessary (PRN), antipsychotic medication to control untoward behaviour. In discussion with care staff and the scrutiny of the MAR sheets we were assured that non-pharmacological interventions were the preferred method of addressing untoward behaviour.

We saw some prescribed medicines had to be given in a precise manner. For example, some medicines were prescribed to be given before food. We saw the prescriber's requirements were being met. We saw all as necessary (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given.

We saw the provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. As an example we saw protocols were available for care staff to access when administering warfarin where the dose is determined by periodic blood tests.

A care worker we spoke with showed us the medication administration records (MAR) sheet was complete and contained no gaps in signatures. We saw that any known allergies were recorded on the MAR sheet. We asked the care worker about the safe handling of medicines to ensure people received the correct medication. Answers given demonstrated medicines were given in a competent manner by well trained staff.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found that on all

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Is the service safe?

occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

Whilst we were told by both the registered manager and the care worker administering medicines that no-one was receiving their medicines covertly we found an annotation in one person's care plan which indicated the GP had sanctioned the administration of medicines covertly. Discussion with the registered manager clarified the GP had given permission for medicines to be given covertly. However the procedure required under the Mental Capacity Act 2005 and reiterated in the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes guideline (March 2014) had not been followed. As a consequence covert administration of medicines had not taken place. During our inspection the registered manager contacted the GP and made arrangements to review the person's prescribed medicines and method of administration.

We looked at the systems in place at the home for accident and incident monitoring and we were shown records which showed a number of falls had occurred at the home between 18 January 2015 and 5 March 2015. These were 33 falls in January 2015, 23 falls in February 2015 and 17 falls up to 5 March 2015. We spoke with the deputy manager and the registered manager who told us there had been a number of referrals made to the falls team. They said some people now had sensors in place in their rooms which would alert staff to their movements.

We looked at the way staffing levels were determined at the home. We found a total of 11 carers were on duty on the morning of our visit. These were supported by a deputy manager who was supernumerary and two senior carers. We were told by the registered manager that there were 66 people using the service at the time of our visit which meant a carer/service user ratio of 1:6. The registered manager informed us that staff allocation was based on 'floors' rather than the dependency of service users. They also told us they completed a monthly dependency tool which we looked at. This showed there was enough staff on duty in terms of numbers however; we did discuss the deployment of staff in the home with the registered manager. They told us they were able to increase staffing when required and would always ensure that where the dependency of people increased, they would ensure staffing levels reflected this.

Requires Improvement

Is the service effective?

Our findings

Our last inspection took place in May 2014 and, at that time; we found the service was not meeting the regulations related to meeting nutritional needs. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked and found improvements had been made however, we found the dining experience for people using the service was not consistent throughout the home.

We observed during the lunch time meal on two of the units in the home and found that service users had mixed experiences. The service used an outside provider for catering needs. The meals were delivered to the home and heated to a recommended temperature before being served to people. We saw staff on the units were available to give assistance with meals to people who needed it. Where people were at risk of losing weight we saw there were food charts in place and we were told everyone was weighed weekly.

On one unit we saw the dining experience appeared to be a pleasurable experience for people who used the service. People had chosen their meal the day before, however, staff were observed reminding people what they had ordered. Food looked appetising and portion sizes seemed appropriate and staff were observed offering people more. We saw people were offered a choice of either a hot or cold drink. A person who used the service told us, "The food's good, not bad." Another person said, "The food is nice, very nice." The menu contained at least two choices for each meal and there were also a further eight choices on the 'A La Carte' menu.

We were told baking was done daily and that people would shortly be taking part in a 'tasting day' for the summer menu. We saw people were able to choose where they ate, some people sat at dining tables and others chose to eat in their arm chairs. The tables were set with linen, cutlery and condiments.

On another unit, we saw the tables were laid with cutlery and napkins. Each table had a pitcher of fruit cordial for service users to enjoy. However, although condiment sets were placed on each table, the salt cellars were empty. Service users were given glass stemmed wine glasses for their cordial drink. One staff member commented, "This is great, most of them think that they are drinking wine."

Lunch time on the unit was planned for 12:30pm. However, we observed carers escorting service users into the dining room from 12:00 onwards. This meant some people were sat for lengthy periods of time before their lunch was served.

We saw there were no offers from staff for people to wash their hands or use hand wipes prior to meals being served. The deputy manager told us these are given out at the end of the meal. We saw this was not done.

At one time whilst staff were assisting a person with their care needs, the serving member of staff was plating the meals but there were no other staff members present to deliver these to the tables. Eventually the server plated and delivered one meal at a time until the staff member returned. This appeared to be a prolonged and unnecessary experience for the service users.

On the day inspection, one of the main choices had been changed by the provider at the last minute and a substitute meal was sent. On serving the meals we heard service users mentioning that they did not order this particular meal. We also heard people saying the meal had been changed. Staff did not establish if the service users liked the substitute meal and also people were also not offered a choice from the a la carte menu. We saw evidence which showed the dining experience for people was monitored on a monthly basis by the registered manager.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that four people using the service were subject to authorised deprivation of liberty. Our scrutiny of people's care records demonstrated that all relevant documentation was securely and clearly filed. Whilst no conditions had been imposed in the authorisations staff were aware of the need to check all new authorisations to ensure the deprivation of liberty remained lawful.

Our observations of the environment and people's care plans that were not subject to DoLS suggested the provider utilised a number of methods which may constitute a deprivation of liberty. Some care plans recorded diagnoses and other indications of reduced mental capacity. The front

door was locked and the four designated areas of care within the home were accessed through locked doors. The registered manager informed us some people were under constant supervision and many were assessed as requiring one to two hourly observations through the night. Our tour of the building, a random sample of rooms and discussions with the registered manager showed 12 people had alarm mats at the side of their beds. The registered manager assured us they would ensure all people who may be being deprived of their liberty would be prioritised for assessment and where necessary make application to the Supervisory Body.

When we returned to the home on the second day of our inspection we were told the registered manager and the deputy manager had submitted the remaining number of applications to the local authority. We also saw evidence which showed there had been a limit set by the local authority regarding the number of non urgent applications they would accept at any one time.

We spoke with the registered manager about the use of restraint. They told us whilst the provider had a restraint policy in place restraint was not currently used.

We saw evidence submitted by staff to a best interest meeting prior to an authorisation to deprive someone of their liberty. The record of the best interest meeting described the person was being restrained to protect them from harm. An examination of archived incident records showed that on one occasion the person had been restrained during the period around the time the DoLS application was being made.

We were told by staff of a technique prescribed by the registered manager which constituted restraint. This technique required two care staff to walk closely either side of a person exhibiting challenging behaviour, with both members of staff cupping the person's hands to protect other people from injury. Associated with this technique staff were told to block people's feet with theirs to prevent being kicked. We could find no evidence in care plans or policy documents which described when this technique could be used and in a manner which respected people's dignity and protected human rights.

We spoke also with the registered manager about the use of bed-rails. Answers we received demonstrated that when people had capacity they were consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, family members were consulted before bed-rails were used. This was to ensure they understood the needs for their use. However, we were told bed-rails were not in use in the home yet in five rooms we found bed-rails attached to beds. Subsequent discussion with the registered manager resulted in four bed-rails being removed as they were not in use. However in one case bed-rails were in use. We saw an assessment of need had taken place. The person had capacity to understand the need for the bed-rails and was in agreement. We saw the use of bed-rails was used in conjunction with lowering the bed to its lowest point as an added help to prevent injury if the person rolled out of bed.

The Mental Capacity Act 2005 covers people who can't make some or all decisions for themselves. The ability to understand and make a decision when it needs to be made is called 'mental capacity'. We spoke with staff about their understanding of the Mental Capacity Act 2005 and most were able to talk confidently about how it impacted on the way they cared for people. One member of staff said, "It's all about helping people to make their own decisions." Another member of staff said, "Even if someone lacks capacity they can make some decisions, we are here to assist without discrimination."

Staff were able to describe clearly the needs of the people they supported and knew how these needs should be met. We looked at the staff training matrix which showed the majority of staff had completed all of the mandatory training they required for their role. This included first aid, infection control, fire safety, food hygiene, medication awareness, safeguarding and moving and handling. We also saw staff had completed training which the home considered to be 'best practice' which included dementia care, challenging behaviour, sensory loss and team leading. This meant people living at the home could be assured that staff caring for them had up to date skills they required for their role.

Staff we spoke with told us they thought their induction training had been comprehensive and covered for example, moving and handling, health and safety, food hygiene and safeguarding. We were told staff would initially observe and shadow their colleagues for the first couple of weeks. One person said, "I was already a carer before I came here, but I found the induction really good and it prepared me to work

Requires Improvement

Is the service effective?

at Springfield." Staff told us there was lots of training, a lot of courses were e-learning, one person had recently completed a medication refresher and someone else said they had been trained in 'behaviours that challenge'.

Staff told us they had regular opportunities to give their point of view about the service, we were told this was in either their supervision meetings or during their annual appraisal. Staff told us they were supported by the registered manager through a three monthly supervision programme. Records we looked at confirmed this. Staff told us they felt this was effective and helped them to enhance their confidence and knowledge that allows them to provide an improved service for service users.

The units specifically for people who were living with dementia were laid out, people were able to walk around the unit freely with interesting items to touch and look at.

Staff told us people had regular access to other health professionals, for example chiropodists, dentists and an optician visits the service. A member of staff said one person had got pressure area damage but the visiting nurses were very pleased with how it was healing. Records showed people using the service received additional support when required for meeting their care and treatment needs.

The deputy manager told us there were three insulin dependent diabetic service users who had their insulin administered and blood sugars monitored by the District Nurse. They told us that senior carers and a 'handful of experienced carers' checked the blood sugars of the tablet or diet controlled diabetics (type II diabetics). This procedure includes pricking the finger of the person, drawing their blood onto a reader strip and waiting for a blood sugar recording. The deputy manager confirmed that staff had not received any training regarding this. We asked under whose instructions staff were taking blood sugar samples of type II diabetics as this was not a current requirement in type II diabetes management unless instructed to do so by a clinician. The deputy manager advised that they could not supply any clinical instruction as to why service users with type II diabetes have routine blood sugar checks. We discussed this with the registered manager who agreed to look at these concerns with the deputy manager.

The registered manager reported that no pressure sores were present on any service user. They told us that when a divan mattress was condemned, a profiling bed and air mattress would be purchased and used as a preventative measure in prevention of pressure ulcer development. We looked at mattress audits which had been completed by the registered manager on a monthly basis. These showed that all of the mattresses in place for people at the home were in good condition.

Requires Improvement

Is the service caring?

Our findings

Throughout the day we observed staff interaction with people on three of the four units within the home. Most staff were gentle, patient and respectful. However, on one of the units we observed that very few people had been helped to retain their ability and enjoyment in life. We saw little interaction between people with most preferring to sit alone or in a communal lounge. Many people said very little and some appeared to lack motivation with staff giving little encouragement on a one-to-one basis. There were missed opportunities by staff to engage with people on a one to one basis.

We observed that all service users appeared to be appropriately dressed and groomed. Throughout our inspection we observed people being treated with dignity and respect. It was clear from our observations that staff knew people well and people who used the service responded positively to staff. A member of staff said, "Privacy and dignity just comes naturally, we knock on doors, we try to ensure people maintain their independence. We really try to get to know people, a continuity of care is very important." When we looked around the home we saw people's bedrooms had been personalised and contained items such as family photographs and ornaments. We saw people looked well dressed and cared for. For example, people were wearing jewellery and had their hair combed. This indicated that staff had taken the time to support people with their personal care in a way which would promote their dignity.

We saw staff had a caring, gentle approach to people, we heard one person who used the service say to a member of staff, and "You are lovely." Another person said, "You are a darling girl I would never be without you." We observed staff speaking with people whilst assisting them, for example, a member of staff was helping a person rise from their chair, they explained what they were doing and gave reassurance throughout. The registered manager told us advocacy services were available for people using the service. We saw evidence of this displayed in the home. We also saw involvement of an advocate in one person's care records.

All of the staff we observed offering people support demonstrated having caring attitudes. However, this was not reflected in one service user's comment of, "Some carers have terrible attitudes. They don't even acknowledge you being here when they come into work. Some carers are lovely and will do anything for you if you ask." Another commented, "Some night staff can be narky and I have heard some raise their voices at people. I haven't reported it as you don't know how far it will go and I don't want to get anyone into trouble."

We looked at the care records of six people and found little evidence to show the involvement of the person concerned. We saw that where documents required signing by the person this had not been done. There were many instances where this was blank. People we spoke with told us they knew they had records which the home kept about their care but had not been involved in developing care plans.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection took place in May 2014 and, at that time; we found the service was not meeting the regulations related to care and welfare of people who use services. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulation. On this visit we checked and found improvements had been made.

We saw the home employed a part time Activity Coordinator for the purpose of arranging and planning activities. We received mixed feedback about the activities available for people using the service. On one of the units, staff told us that people were able to take part in activities most days. Recent activities had been ballroom dancing, bakery, bingo, looking at 'old war books', a visit from a donkey, exercises and for people who were unable to take part staff sat with people on a one to one basis. During our inspection we observed staff sat chatting with people. One member of staff said, "A few months ago we took people to the seaside." A person who used the service said, "There's usually something good on every Wednesday."

On another unit, we did not observe any meaningful activities taking place during our time on the unit. We looked at an activity diary with every days planned activity. On discussing this with a service user they told us, "That's a con don't believe it. The activities coordinator does not come to this unit often. We used to have a game of Bingo but that stopped without any reason given." This meant people living on this unit did not have adequate social stimulation to support their emotional or mental wellbeing.

People told us they felt they had choices in how they spent their day at the home. We spoke with one person who said, "We get choices, I can choose when I want to go to bed and when I get up, nobody forces me to do anything." Another person told us, "I can do what I like; they just let me get on with it. I can watch TV or I like to read. The staff are very friendly and always ask me if there's anything I want or need."

We looked at the care records of six people. We saw the home were using electronic care records for people for the purpose of care planning, risk assessments and daily records. We also saw the where monitoring was in place for people for example, food and fluid monitoring this was done on paper and kept in the person's room. We found people had their needs assessed before they moved into the home. This ensured the home considered how they were able to meet the needs of people they were planning to admit to the home.

We saw each of the care records contained a range of care and support plans which included daily living, personal care, night time support, communication, health/medical, medication and eating and drinking. All of the care plans we looked at were written in a person centred way which provided staff with clear guidance on how to meet the person's needs. For example, 'X (the person) requires a soft diet to meet their oral condition', 'I can express and communicate my wishes but require empathy and patience' and 'X (the person) needs the assistance of two carers for using the toilet. One carer is needed to support with personal care who needs to talk through all support whilst assisting with washing and putting clothing on.' This showed people's care planning was individually tailored to meet their needs.

We saw each of the care records we looked at contained documents 'This is me' for the purpose of gathering information about the person and their life before they moved into the home. A life history document enables staff to understand and have insight into a person's background and experiences. We saw the majority of these had been fully completed however, in one of the care records we looked at; we saw some areas of the document had been left blank.

The registered manager told us there had been issues with people's families being involved in the reviews of care which took place at the home. We saw letters had been sent out to people's relatives inviting them to be involved in reviews. The registered manager also told us people did not always wish to attend care reviews themselves and we saw this was also recorded in people's care records.

We looked at the way the home responded to concerns and complaints. We were told by staff they would assist people if they wanted to make a complaint, they said there was a complaints folder. Staff said they thought people would speak directly to the manager or deputy manager. We found the service had an up to date complaints policy and procedure in place which gave clear timescales for dealing with complaints. We looked at the complaints log and saw the home had received five complaints since our last

Requires Improvement

Is the service responsive?

inspection in May 2014. We saw all of the complaints had been investigated and where possible resolved to the satisfaction of the complainant. This showed the complaints people made were responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

The management structure at the home consisted of a registered manager, a deputy manager and a night manager. We spoke with staff about the management of the home. Staff said they felt supported by the manager and deputy manager. One person said “We do see quite a lot of the manager although she doesn’t come on the unit very often. If we have any problems we report it to the senior.” Someone else said, “I love working here, the majority of people know everyone here.” Another member of staff said, “It’s brilliant working here, it’s probably the best place I have ever worked.” Three service users we spoke with told us they did not see much of the manager’s around the home.

Staff told us there was regular staff meetings held at the home which gave them the opportunity to give their opinions and feedback on the service. We saw minutes which showed regular, monthly meetings had been held with all staff working at the home which included catering and kitchen staff, night staff, senior care staff and the full staff team. This showed staff was appropriately supported in relation to their caring responsibilities and was regularly updated about any changes in the service.

We saw there were systems in place to enable people living at the home to comment on the service provision. We saw that regular residents meetings were held every two months at the home. We looked at the minutes of the meetings from February 2015 which showed a good level of attendance by people using the service. The registered manager told us they experienced a low level of attendance from people’s relatives and they were looking at ways to improve this. This included to times the meetings were held. They also told us that they held a 'weekly after hours surgery' for the benefit of those service user’s families who work office hours. This showed that people’s views and opinions were taken into account in the way the service was provided.

We saw the provider had a quality assurance system in place which consisted of audits which required completion on a monthly basis by the manager. This included audits of accidents, falls, floor management folder, bed rail usage, complaints monitoring, pressure sore, weight loss action plan, medication, infection control, catering, care plans, satisfaction surveys, CQC/safeguarding notifications and the dependency tool. This was then checked by the provider on a monthly visit to the home. We saw that where issues were identified action plans had been put in place. These include achievable timescales to ensure issues were resolved in a timely manner.

The registered manager told us they monitored incidents which had occurred at the home. We looked at these records and although we saw action plans had been put in place, these were not cross-referenced with the individual risk assessments and care plans, to minimise the risk of re-occurrence. Throughout the inspection we identified a number of concerns in relation to monitoring of falls which did not ensure actions taken prevented reoccurrence, deployment of staff was not in relation to dependency needs of people using the service, a lack of consistency regarding the provision of activities. These failings had not been identified through an effective system of quality assurance.