Victoria House (Wallasey) Limited

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Inspection report

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Wallasey
Merseyside
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Tel: 01516387863

Date of inspection visit:
08 March 2016

Date of publication:
25 April 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Victoria House on 8 March 2016. The inspection was unannounced. Our last inspection of the service was on 11 June 2014, when we found that the service was compliant in all areas we looked at. The service is registered to provide accommodation with personal care for up to 56 people.

The home is required to have a registered manager. 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. The home had a registered manager, however he was on holiday when we did the inspection.

During the inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008: Need for consent. You can see what action we asked the provider to take at the end of this report.

During our visit we saw that there were enough staff to support people and meet their needs, and people we spoke with considered there were enough staff. People we spoke with described the staff as kind and caring and we observed positive and respectful interactions between staff and people who lived at the home. Staff had received training about safeguarding vulnerable people from abuse and about caring for people living with dementia.

The home was clean and there were no unpleasant smells. Some improvements had been made to the environment since our last inspection. Medicines were stored safely and people received their medication as prescribed by their doctor.

People were registered with local GP practices and the care plans we looked at gave details of people's health needs. People's needs were assessed before they moved into the home and referrals were made to medical professionals as needed. Care plans recorded the care and support people received.

People who lived at the home had a choice of spacious sitting areas on the ground floor. These included a 'garden lounge', which was a quiet area with no television; a 'ballroom' where activities took place; a smokers' lounge; and a conservatory. People were free to walk around and choose where they wanted to spend their time. People told us that they enjoyed the social activities provided and regular trips out.

People spoke highly of the home manager and staff considered that they worked well together as a team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The home was clean and adequately maintained.

There were enough staff to support people and keep them safe. The required checks had been carried out when new staff were recruited.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not entirely effective.

Deprivation of Liberty applications had been submitted for some people, however arrangements for the covert administration of medication were not compliant with the Mental Capacity Act.

Staff received a programme of training relevant to their work.

People received enough to eat and drink.

Is the service caring?

Good

The service was caring.

We observed staff caring for people with dignity and respect.

People who lived at the home, and their relatives, told us that the staff were kind and caring.

There was a happy and inclusive atmosphere in the home.

Is the service responsive?

Good

The service was responsive.

People had choices in daily living and staff were aware of people's individual needs and choices.

The care plans we looked at reflected people's support needs

and the care they received.

A copy of the home's complaints procedure was displayed and complaints records were maintained.

Is the service well-led?

Good

The service was well led.

The service had a registered manager and people spoke well of him.

There was a positive, open and inclusive culture and people's views were listened to.

Regular checks and audits were carried out but were not always recorded.

Victoria House (Wallasey)

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 took place on 8 March 2016 and was unannounced. It was carried out by two Adult Social Care inspectors 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.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection. We contacted Wirral Council's Quality Monitoring and Contracts department to ask for their comments.

During the inspection we looked at all parts of the premises. We spoke with eight members of staff, four people who lived at the home, and seven visitors. We observed staff providing support for people in the lounges and the dining rooms. We looked at medication storage and records. We looked at staff rotas, training and supervision records, and recruitment records. We looked at maintenance records. We looked at care records for three people who lived at the home.

Good

Is the service safe?

Our findings

People we spoke with said they, or their relatives, were safe living in the home. One person told us "I feel it's nice here." and another person said "I know I can be looked after if anything goes wrong." People told us they felt reassured because external doors were locked and keypad locks were in place on corridor doors. A relative said "I talk with staff and know they care about the people. I visit daily."

We spoke with four care workers. They all said they had received training about safeguarding vulnerable adults from abuse. All understood the types of abuse people might be subject to and discussed the ways by which people were protected. They knew what signs might alert them to issues and how to escalate concerns to more senior staff. Staff also understood that safeguarding might sometimes include protecting people from other people living at the home. Some people had personal spending money in safekeeping at the home. We looked at the records which were maintained in detail and double signed. Finance audits were carried out to ensure people were protected from financial abuse.

We walked all around the building both inside and outside. The ground floor had spacious communal areas and a sufficient number of toilets. Toilets had locks that showed when the room was in use. There were also offices, a staff room, a clinic room, and the kitchen on the ground floor. The first and second floors had bedrooms, bathrooms, sluices, and store-rooms.

Bedrooms were basic and did not have en suite facilities. The maintenance person told us that 30 rooms had been redecorated and re-carpeted, however we noticed thin and stained carpets in a small number of rooms. Most of the windows had been replaced, however we found two bedrooms had old sash windows that could be opened widely enough for someone to crawl out of. We brought this to the attention of the maintenance person who took immediate action. A number of old windows were in poor condition and the maintenance person told us that replacements had been ordered for all of the old windows. Radiators had protective covers to prevent the risk of burns. There were padlocks on the cleaning stores. A plan of redecoration and replacement of flooring was being followed. Alterations to the smoke room were almost complete to improve ventilation in this area.

The home employed one full-time and one part-time maintenance person. They had a large space in the basement to store tools and equipment. The maintenance team had been provided with some basic information about the people who lived at the home so that they were aware of any particular individual needs. A 'day diary' recorded maintenance requests and tasks completed. Certificates and records were in place to show that up to date checks had been carried out on the lift, small electrical appliances, the fire alarm system, and the gas and main electrical systems.

The building had several external fire escapes, and ramps and evacuation equipment was available. The fire escapes were clear but there was some other rubbish and old furniture around the outside of the building that needed clearing. There were door-guards on bedroom doors so that people could have their bedroom door open safely. A fire risk assessment had been written in 2012 and reviewed in December 2014. This included an emergency evacuation plan to local premises. A fire officer had visited in December 2014 and

there was a record of actions taken to address issues they had identified. For example, additional smoke detectors and some new emergency lighting had been installed. A fire alarm inspection had taken place in January 2016. There were individual fire risk assessments for people who lived at the home and copies of these were kept in a folder in the main office by the front entrance. Staff had done fire training in February 2015.

Everyone we spoke with thought the home was clean and well maintained. We saw daily cleaning schedules that were completed for the month of January 2016. An NHS infection control audit had been carried out on 5 November 2015 and recorded a score of 83%. Issues identified as requiring improvement mainly concerned the laundry. We visited the laundry, which was in the basement and was spacious. There were two washing machines, one of which was not working. The laundry staff were certain that it would be fixed soon. There was a large old stained sink that staff told us was going to be replaced following the infection control visit. The kitchen had a four star food hygiene rating. A water hygiene log book recorded that a Legionella test had been carried out on 2 March 2016. There were also records of monthly temperature checks of hot and cold water outlets and shower heads sterilisation.

Everyone we spoke with said they thought there were generally enough staff to care for them, with an odd occasion due to unforeseen circumstances being the only time people felt the home was short staffed. People said "There are staff around, I don't have to wait."; "I never have to wait for anything"; "There are occasions when staff are off and meals are a bit late". During the inspection there were always staff around when we needed to ask them anything. People were walking freely through the home and in case of spillages, warning signs were put near them and cleaners attended to them promptly. Care staff were visible around the home and spent time in communal rooms with people. Care staff we spoke with all felt there were enough staff to care for people safely. We saw staff going into the different lounges throughout the day.

The staff rotas we looked at showed that during the day there was always the manager or the deputy manager on duty. There was a total of 12 senior care staff with at least one senior care worker on each shift. Six care staff were on duty during the day, five in an evening and four at night. The deputy manager told us there was some use of agency staff from two local agencies. We saw that the home received basic information about the members of staff sent by the agency and this confirmed they were safe to work with vulnerable people.

In addition to the staff who provided direct care, the home had an administrator, a full-time and a part-time maintenance person and a part-time minibus driver. A cook worked between 8am and 5pm supported by a kitchen assistant in the morning and evening. Four housekeeping staff were employed for cleaning and laundry duties. The manager told us that there was a low turn-over of staff.

We checked the personnel files for three care workers. They had completed an application form and been interviewed before being offered employment. Gaps in their previous employment had been explained. Two references had been provided for each, including one reference from a previous employer. References included indications of each person's trustworthiness, honesty and integrity. Each applicant had provided two forms of identification such as a passport, birth or marriage certificate. A disclosure and barring service (DBS) certificate had been seen by the manager before staff started working at the home.

The service had a medication policy which had been reviewed and updated in January 2016. There was an effective system for ordering medicines on day 14 of a 28 day cycle. This meant that the staff could make sure that people had all their medicines for the forthcoming month. Most medicines were supplied in a 'NOMAD' boxed system. Excluded from this were 'use as required' medicines (PRN), short term medicines such as antibiotics, liquid medicines, and medicines that needed to remain in the manufacturer's packaging

until used. Medicines were stored securely. A medication fridge was locked and staff ensured the temperature remained safe by checking it daily.

When medicines were delivered to the home by the dispensing chemist, they were checked in. The number of tablets supplied and brought forward was recorded on the medicine administration records (MARs). We saw the administration of medicines was carried out safely. Two senior care staff wore 'Do not Disturb' tabards. These helped to reduce interruptions to staff administering medicines, as this can increase the risk of errors.

People living in the home liked to get up at different times in the morning. Care staff helped people to wash and dress and escorted them to the dining room. A senior carer welcomed them, helped them to sit at a table and asked if they were ready for their medicines. Then they alerted kitchen staff that the person was ready for breakfast. We saw one person wanted to wait until they had a hot drink before taking medicines and the care worker left them with a cup of tea and came back to them later.

Staff carefully checked the MAR for each person as they prepared the correct medicines. We saw they took the MAR to each person with their tablets. They carefully checked each tablet in the pre-packed box against descriptions printed on the MAR before giving them to the person. Staff were patient and supportive as they helped people take their medicines. One person placed tablets on the table and took them slowly. A care worker observed carefully from a distance, moved closer and encouraged them then stepped back again. Once the person had taken all the tablets, the MAR was signed.

Care staff used a printed list of names of people living in the home to manage the way medicines were given as people arrived, making sure no one was missed. As each person received their medicines, the care worker circled their name. That way they could see at a glance who still had not received their medicines. Some people spent the day in their bedrooms and care staff took their medicines, with their MAR, to them in their bedrooms. Staff told us night staff gave some early morning medicines.

A separate sheet in the MAR file showed the specific indications for use of an 'as required' medication. Care staff wrote relevant comments on the reverse of the MAR, such as why PRN medication had been needed. We looked at the MAR sheets for ten people. All had a recent photograph of the person to help staff identify people safely. All had any known allergies recorded and specific person-centred information about their resuscitation status, swallowing difficulties and deprivation of liberty (DOLS) status. They also included contact details for each person's GP.

We saw that no medicines had been unsigned for or omitted in the previous weeks. A key on the MAR explained the use of letters such as 'R' for refused or 'H' indicating hospital admission. The MAR file included a list of care workers deemed competent to administer medications with their signatures and initials. We saw 'body maps' in people's bedrooms that showed where prescribed topical creams or ointments should be applied.

It was not always easy to see when staff had signed to show people had received PRN medicine. This was because staff entered 'R' in the box showing people had refused. This can cause confusion as PRN medications can be needed at any time, not just the 'set' medication administration times. If a chart has already been completed with 'R' four times in a day, there is no room to sign for a dose given overnight. Also, the exact time should be recorded to ensure the prescribed time intervals are adhered to. We discussed this with senior carers.

Requires Improvement

Is the service effective?

Our findings

People told us they had enough to eat and drink throughout the day and night. One person said "I drink a lot of water, and I have fresh orange juice and cranberry juice." The comments people made about the quality of meals were mixed. One person told us "It's very nice, I don't know what I'm having for lunch though. There is a choice of two things." Another person said "It's fantastic, but I don't know what's on the menu." Another person said "It's not very good, you get the same thing week after week." Relatives told us "She loves it, it's lovely, and she can have a drink whenever she wants one." and "She eats less here than she did at home." We asked people if they could have a hot drink when they wanted one and one person told us "I think I could have a cup of tea now if I wanted one."

The home was trialling the use of prepared frozen meals especially made for care homes and the cook explained to us how the system worked. She told us it was working particularly well for people who had special needs, for example a soft diet, and they had put on weight. The system provided more variety than she was able to.

We observed breakfast being served in the main dining room and lunch in the smaller dining room. People ate breakfast at different times depending on when they chose to get up. We saw they were asked what they wanted and cereal and toast were served. Several people lingered in the dining room drinking tea. Care staff assisted people who needed help and at least one member of staff remained in each room until people had all finished.

At lunchtime, 11 people who needed some support with their meal sat in the smaller dining room and a care worker sat at a table with four people. Three people wore aprons to protect their clothing. Another care worker served food and helped people as they needed it. The day's menu was displayed on the wall. A care worker said some people could not read the menu and they always explained the choices available.

People were asked what they wanted for lunch about 20 minutes before it was served. There was a choice of sandwiches, soup, or a light cooked meal. The main meal would be saved later in the day. The expert by experience had lunch with people in the dining room. The hot meal was cauliflower cheese with potato croquettes and peas. The expert by experience considered that the cauliflower was over cooked and the cheese sauce was very thick and tasteless. Two people had soft diets. These consisted of meat and gravy, vegetables and potatoes. These had all been prepared separately and the meal looked appetising. These, and several other people's meals, were served in adapted plates that were curved at the edges and enabled people to eat unaided using only a spoon or fork.

A care worker told us they made a note of how much people who were identified as being at risk of poor nutrition ate and passed the information on to a senior carer. They told us a person had been losing weight and not eating well. They had been reviewed, a soft diet introduced, and their appetite had increased. People were offered a drink of orange juice but were not offered any other choice of drink.

Records showed that new staff received an induction when they had started working at the home. Induction

included fire safety, moving and handling and dementia awareness. Care staff with little or no previous experience of care had undertaken a period of shadowing senior care workers before working alone. We looked at the service's training matrix and saw that staff had received training about safeguarding, moving and handling, first aid, fire awareness, health and safety, managing challenging behaviour, equality and diversity, dementia care, dignity and respect, prevention and control of infection, pressure care, and report writing. Only a small number of staff had done training about food hygiene, nutrition, and mental capacity.

Staff we spoke with said they could ask for additional training and were confident the manager would support them. One care worker said they had recently asked about training to care for people suffering with Parkinson's disease and expected to do this in the future. All of the care staff we spoke with said they had an annual appraisal and regular supervision meetings with the manager. The manager told us that 90% of the care team had a qualification and most were working towards a higher level qualification.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

In the Provider Information Return (PIR), the manager stated that 28 people had their liberty, rights and choices restricted in some way and six people had a DoLS in place. It was not clear how it had been decided which people required a DoLS application and how many, if any, other applications were awaiting a decision by the local authority. Only the senior staff had received training about the Mental Capacity Act and DoLS, however the manager informed us that mental capacity and DoLS were always discussed at staff meetings. One of the care staff we spoke with said they had not received training about mental capacity and DoLS and did not really understand it. Three other care staff knew mental capacity involved people's ability to make decisions but were unsure of the test for this. They knew DoLS were put in place to protect people who might not be safe going out alone, but were not clear which people had been formally assessed or who had a DoLS in place. We did not see consent forms or capacity assessments in the care files we looked at.

We saw some people were given medication covertly. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication. Care staff relied on a letter from people's GPs stating medicines could be given covertly in food or drink. The policy of the service was for a full mental capacity assessment to take place before considering covert medications. It also said a pharmacist should review the person's medicines.

We looked at records for two people receiving medicines covertly at the home. Both had a letter from their GP agreeing to this. One of these letters was from January 2014 and we saw no record that it had been reviewed. Neither person had had a mental capacity assessment prior to the decision being made. We saw no evidence that a pharmacist had reviewed the people's medicines in relation to giving them covertly. This is important because some preparations should not be crushed and mixing medicines in different food might affect their effectiveness. We did not see that care plans were in place and reviewed for the administration of covert medication.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for Consent

On the ground floor, people had a choice of spacious sitting areas which were all on the same level. These included a 'garden lounge', which was a quiet area with no television; a 'ballroom' where activities took place; a smokers' lounge; and a conservatory. There was a shower room on the ground floor which was accessible for people with mobility difficulties, and toilets had wide doors which would accommodate wheelchairs. We noticed that only a small number of the bathrooms on the first and second floors were adapted for people with disabilities and others appeared to be unused. We saw equipment in use in people's bedrooms including hoists, pressure relieving mattresses, bed levers, and alarm mats. We noticed that there were no names or pictures on people's bedroom doors to help people identify their room.

There was a patio garden at the back of the house but it was not secure for people to use unsupervised and it was not easily accessible. In the PIR the manager told us 'During the next twelve months we plan to further develop the facilities available at the home with the introduction of new wet areas upstairs to enhance choice of how individuals wish to receive personal bathing support. Access to the rear garden for summer days is under development as it needs to have a secure external perimeter to protect those who choose to go outside and use it.'

Good

Is the service caring?

Our findings

People told us they were encouraged to be as independent as possible, but help was there if they needed it. One person said "Now and again they have to tell me about a new change of clothing, and as soon as they tell me I go and get changed." A relative told us "She needs help with washing and dressing, but is encouraged to do what she can for herself."

We asked people what they thought about the staff. People who lived at the home told us "They're very nice."; "They're excellent, polite and kind."; "They're alright, they come in and give me my dinner. I ring the bell if I need them." and "They're fairly good." Relatives said "They're very nice, very kind."; "They're lovely, they've become friends. I get calls if they're worried about her or if she goes to hospital. She gets clean clothes and bedding every day, I just can't fault them."; "I think they are very good, very friendly, always smiling." and "I think they're wonderful."

We spoke with two visitors whose relative recently went to live at Victoria House and asked them whether this had been a difficult time. They told us "They made it easy, the staff are so beautiful, so kind, he is really well looked after. Staff are marvellous, he gets choices all the time. Other families we have spoken to all think the same."

We asked people what they liked best about the home. One person said "It's a nice atmosphere, everybody is friendly. We can all have a laugh and have a laugh with the staff." Another person told us "I just please myself." A third person commented on "The cleanliness, the brightness and the pictures on the walls". A relative said "The residents are lovely and the staff are so kind and helpful. It has a nice atmosphere, it's that nice I don't want to go home." and another "The staff are excellent, and Mum is safe and warm."

People told us that visitors were welcome at any time. Throughout the day of our visit we observed interactions between care staff, people living at the home, and their visitors. These were all pleasant and cheerful, patient and kind, and involved humour where appropriate. For example, as each person was supported to go into the dining room in the morning for breakfast they were welcomed by name, with a smile. One person was dressed elegantly with a scarf and jewellery and make up. It was clear she took pride in her appearance and staff had supported her to maintain this. Other people were dressed more casually showing individual choice had been respected.

In the PIR the manager told us 'On behalf of my staff team I have received numerous letters and cards thanking us for the care of their loved ones, whether they have passed away or just in general appreciation for the work that the team does here. We have had compliments from the public during day trips out. They have bothered to take down the home's number off the mini bus and ring the home, saying that they had been parked close by to the bus and commented on the care displayed towards our residents. Families at funerals have paid glowing tributes to the care and dedication their loved ones have received.'

The deputy manager was unable to find any written information about the home that could be made available for visitors or for people who lived at the home to inform them about the services that were

available. We noticed that staff did not wear name badges and there were no photographs of the staff to help people identify any individual member of staff.

In the PIR, the manager told us that the home was close to achieving the recognised award Six Steps for end of life care. At the time of our visit nobody was receiving end of life care at the home. Communion was offered every Friday by local clergy.

Good

Is the service responsive?

Our findings

We spoke with a visitor who went to the home to see their relative four or five times a week. They described how the home manager visited their home to assess their relative and offered a month trial period to see if this would be the right place for them. They said they had no complaints and were very satisfied. Their relative had dementia and they were "very, very pleased" with the way their relative's dignity was maintained. A special diet was catered for. They had been shown the care plan and DoLS had been discussed. Another relative told us "I couldn't have had more help getting her settled."

People told us they could choose when to get up and go to bed and they could make choices about where they spent their time during the day. Relatives told us that, as far as they knew, people could get up and go to bed when they wanted and one relative added "She chooses her own clothes." We saw people chose to spend their day in different areas of the home and there were several communal areas to choose from. These had different atmospheres. A conservatory was bright and quiet. Two lounges had televisions on showing different programmes and people were watching them. We saw a person sitting alone listening to loud music which they appeared to enjoy. A small number of people chose to spend their day in their bedroom.

Relatives told us the home was quick to contact health care professionals when needed and that family members were informed and kept up to date with the person's condition. A relative said "If he has needed any medical help, they have been spot on. If he goes to appointments, someone goes with him." Another relative told us "Mum gets her hair done every week, she has a daily paper, the chiropodist comes and she sees the optician."

Staff used a daily list of professional appointments to record visits from doctors, nurses, or other health professionals. These included the reason for the visit, the outcome and any resulting changes in the person's care plan. This was used to handover to the next shift, update individual records and then passed to the manager to keep him updated. The care staff we spoke with had a good knowledge of people's individual care and support needs and they had all completed dementia awareness training.

We asked people if they had been involved in care planning and most people told us that they had some involvement. We looked at a sample of people's care files. The care files contained assessments that had been completed before the person went to live at the home. Assessments had been carried out by a senior member of the home's staff and there was also information from social services. These ensured that Victoria House would be the right home for the individual and their needs could be met.

Care plans had sections entitled 'historical and current condition'; 'aims and objectives' and 'staff support – action required'. This reflected a positive approach to supporting people and did not label people as having 'problems' or 'needs'. The care files contained personal details, a list of medication, medical information from their GP, a personal history and life story, and finance details. There were risk assessments covering areas such as nutrition and falls, and records showing that people's weight and blood pressure were monitored. The plans for people's care had been written in detail and kept up to date. Records showed that

people had home visits from health professionals including district nurse, community matron, chiropody, GP, dentist, dietician, and were supported to attend medical appointments. Some of the people who lived at the home were living with dementia and received support from community mental health services.

In the PIR, the manager told us 'We strive to offer a wide choice of services to our residents including activities, day trips, entertainment, podiatry care. We produce a newsletter for residents and their families. These are all free of charge. There is a hairdresser available every Thursday and in house screening also includes opticians and dentists.' There was an activity programme that covered a wide range of interests and people were encouraged to join in if they wished. The home had a mini bus and trips out were organised twice a week. Other people preferred to go out on an individual basis.

We asked people how they spent their time during the day. One person replied "I just sit here and we do different things." Another person said "I like gardening and go outside in the summer. I like the trips out to Royden Park. I have a laptop and I play Solitaire on that. I've got internet, but I'm a little out of range. I'm going on the trip today." A third person said "I do word search and watch TV. I go for a half hour walk in the corridor and I do my exercises." A fourth person told us "I spend my time mostly lying down, I don't have much motivation." Relatives said "She colours in and draws, plays bingo and sings along when the groups are on. I take her out as well."; "She sat in the lounge and was encouraged to join in. She likes going out on the bus and the clothing and shoe parties they have here." and "She likes sitting in the conservatory watching the traffic and the entertainment. She's been out on the bus as well."

The activity coordinator told us there were mini bus trips twice a week on a rota basis, to ensure everyone who wished to got a chance to go out. Other activities included poetry reading; reminiscence; art classes; Easter bonnet decorating; skittles; bean bags; Velcro dart board; entertainment twice a month; school involvement, both primary and secondary; pamper afternoons; bingo and musical bingo. The small dining room was the "football room" and the room had been decorated for the World Cup.

We asked people if they knew how to complain. One person replied "No, not really, I've never complained." Another person said "No, I've never had to." A third person said "I'd ring the buzzer and get one of the girls." A fourth person said "Yes, I'd get whoever has seen to me, or the senior." A relative told us "Yes I know how to complain, but I haven't needed to. I might come in here when I'm old." A second relative said "I'd look it up, but first I'd speak to the manager. I've spoke to the manager about the incontinence and this was resolved straight away." None of the other relatives we spoke with had had cause to complain.

The home's complaints procedure was displayed in the main entrance area. We noticed that it did not give the name of the manager or contact details for the manager or the provider. CQC had received one concern about the service and we discussed this with the deputy manager. They told us about how the issue had been resolved. One complaint had been recorded and dealt with by the manager during the last year.

Good

Is the service well-led?

Our findings

The manager was on holiday when we inspected the home. The deputy manager was in charge, supported by an administrator. During the day, many people spoke of the manager and the deputy manager by name and clearly knew them well. The deputy manager was visible in the home throughout the day of our inspection. A care worker said the manager was "really nice, a good manager… helped me through a lot." They said the home had a friendly atmosphere adding "We all work together as a team." Another member of staff said the best quality of the manager was that "He listens to us." Another member of staff said they could speak to the manager about anything and the manager had supported them with NVQ studies. They said it was a good place to work.

We asked people if there were any meetings for people who lived at the home and their relatives. Most people said they didn't know about any meetings, but one person replied "Meetings? Yes, I go if I'm available. I think they are about every six months." Another person said "I think there are meetings, but I don't go any more." Following our inspection, the manager provided details of when meetings for staff and people who lived at the home had taken place during 2015 and 2016. Staff meetings had been held three monthly, with additional meetings for senior staff. Various ways of communicating with people who lived at the home and their families included bi- monthly newsletters published by the home, a weekly activity board, and residents/ family meetings every two months. The meetings mainly focussed on social activities and where people would like to go for trips out.

We asked people if they had completed a questionnaire about the service. Two people who lived at the home said they had filled in a survey, but none of the relatives had. We found some completed satisfaction questionnaires but they were not dated. The deputy manager thought the survey had been done during summer 2015. We did not see any analysis of the responses received or an action plan to address any issues raised.

We looked for evidence of how the quality of the service was monitored. In the PIR, the manager told us 'Dignity and Dementia champions monitor the practice of the staff team within the home.', however we did not see any records to show how this was done or how areas for improvement were identified and addressed. The deputy manager told us, and showed us evidence, that a member of the administration staff checked to make sure that care plan reviews had been done each month and alerted staff if any were overdue. A monthly medicines audit consisted of counting the numbers of tablets supplied in the NOMAD system, how many had been given, and how many were returned to the chemist at the end of the month. It did not check the count of medicines prescribed to be given PRN, and there was no recorded audit of MAR charts. Adding these to the audit format would help to make it a more robust process. Finance audits were carried out and recorded to ensure people were protected from financial abuse.

We saw that a monthly accident audit was recorded and records of untoward incidents were well-maintained. We saw that the housekeeper maintained daily cleaning schedules but we did not find evidence of internal infection control audits. An 'owner monthly report' was written monthly and included comments about 'residents, staff, environment, and social events'. The manager told us that planning meetings were

held with the provider every six months.

In the PIR, the manager told us 'We regularly subscribe to organisations who keep us up to date with legal and required improvements within our care sector.'

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	Regulation 11 HSCA RA Regulations 2014 Need for consent Not all staff had received training about mental capacity and consent. Arrangements for the covert administration of medication were not compliant with the requirements of the Mental Capacity Act.