Mrs I Austen

Lebrun House

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

Lebrun House is a care home that provides accommodation for up to 20 older people who require a range of care and support related to living with a dementia type illness and behaviours that may challenge. On the day of the inspection 16 people lived there. There is a registered manager at the home. 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.

This was an unannounced inspection and took place on 3, 4 and 5 February 2015.

At our last inspection of 20 July 2014 we found the provider had not met the regulations in relation to the safe management of medicines and records. The provider told us they would be making improvements. At this latest inspection we found further improvements were still needed. Photographs to help staff identify people were not in place in the medicine administration records.

Staff did not have a clear understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Summary of findings

Doors to the home were locked and people were unable to leave the home when they wished. However, there was no information in people's care plans to show the restrictions were appropriate for everybody.

There was induction training in place when staff started work at the home. However, they had not received regular training and updates in line with the provider's policy and this needs to be improved. We saw further training had been booked. Staff had a good understanding of the care they provided to people.

Staff knew people well; they had a good knowledge and understanding of the people they cared for. They were able to tell us about people's care needs, choices, personal histories and interests. We observed staff caring for people with kindness and respect. People were comfortable in the company of staff and approached them freely. However care records did not contain enough information to guide staff to ensure people received a consistent level of care.

People were supported to take part in a range of activities and visitors told us they were always welcome at the home.

There were enough staff working at the home and recruitment processes ensured the registered provider employed staff who were suitable to work with adults. Staff understood safeguarding procedures and what they needed to do to protect people from the risk of abuse.

Healthcare professionals including GP's, district nurses and mental health team were involved in supporting people to maintain their health.

Breakfast and lunchtimes were relaxed, sociable occasions. People were offered a choice of nutritious meals and were supported to eat and drink sufficient amounts.

There was a complaints policy and procedure in place, and complaints were responded to appropriately.

We observed staff offering people choices and helping them to make decisions throughout the day.

The culture within the home was open, staff told us all staff worked together as a team and supported each other.

There were a number of breaches of the regulations. 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.

People's medicines were not always managed safely. There were no photographs in place for staff to correctly identify people. Staff did not follow their own medicine policy in relation to homely remedies.

Staff understood the procedures to safeguard people from abuse.

There were appropriate staffing levels to meet the needs of people.

Recruitment records evidenced there were systems in place that helped ensure staff were suitable to work at the home.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not have a clear understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Doors were locked at the home, however there was no documentation to demonstrate the restrictions were appropriate for everybody.

Staff had not received regular training and updates in line with the provider's policy. However, we saw further training had been booked.

People were supported to maintain a balanced and nutritious diet. Mealtimes were relaxed and sociable occasions.

People were supported to have access to healthcare. This included GP's, district nurses, dieticians and mental health services.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with kindness, compassion and understanding.

Staff supported people to make their own decisions and choices throughout the day.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People received care and support that was responsive to their needs because staff knew them well. However, some of the care records required updating. This meant there was no guidance for staff to ensure consistency or demonstrate that people's care needs were being identified and met.

Summary of findings

There was a complaints policy and procedure in place, and complaints were responded to appropriately.

Is the service well-led?

Some aspects of the service were not well led.

We had not been notified as legally required about the absence of a registered person.

Although there were systems to assess the quality of the service provided these were not always effective.

There was an open, relaxed atmosphere in the home and staff felt supported.

Requires Improvement

Lebrun House

Detailed findings

Background to this inspection

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

This inspection took place on 3, 4 and 5 February 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete 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 reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

During the inspection seven people told us about the care they received. We spoke with ten members of staff which included the registered manager and provider and one visitor. Following the inspection we spoke with three further visitors and two visiting health care professionals. We observed care and support in communal areas and looked around the home, which included people's bedrooms, bathrooms, the lounges and dining area.

People who lived in the home were unable to verbally share with us their experiences of life at the home because of their dementia needs. Therefore we spent a large amount of time during our inspection observing the interaction between staff and people and watched how people were being cared for by staff in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a variety of documents which included five people's care plans, four staff files, training information, medicines records, audits and some policies and procedures in relation to the running of the home.

Requires Improvement

Is the service safe?

Our findings

Relatives and visitors told us they felt people were safe at the home. One visitor said, "I can go out the door and feel she is safe and looked after." At the last inspection 20 July 2014 we asked the provider to make improvements in the management of medicines. The provider sent us an action plan stating they would have addressed all of these concerns by November 2014. At this inspection we found although concerns identified at our last inspection had been addressed there were still some areas of medicines that needed to be improved to ensure they were safe.

There were medication administration record (MAR) charts in place for everybody. However there were no photographs in place for staff to identify people. Staff who administered medicines had worked at the home for some time and knew people well. We were told there had been photographs in place but these had been returned to the pharmacy when the provider changed to a new medicine supplier. We saw photographs had been taken for everybody but these had not yet been printed out.

Some medicines were required to be stored in the fridge. We saw the fridge temperature had not been monitored. This meant medicines may not be effective as they had not been stored correctly. This could leave people at risk of inappropriate treatment. We were told the new medicine supplier had not yet provided a fridge thermometer. The registered manager told us they would contact the supplier and order one.

One person had been administered and taken a painkiller which had not been prescribed on the MAR chart. It had been recorded on the back of the MAR chart what the medication was, why it was required and when it was given. The deputy manager told us this person had been discharged from hospital and information in a letter to the person's GP stated this person could take the pain killer if required. There was no copy of this letter available and the information had not been recorded in the person's care plan or daily notes. The deputy manager told us they were able to administer the medicine as a 'homely remedy'. Homely remedies are non-prescription medicines or other over-the-counter-products for treating minor ailments such as coughs or minor aches and pains. There was a 'homely remedies' policy in place which stated that the GP, pharmacist and provider should compile a list of homely remedies and these should be regularly reviewed. However, this list was not in place so there was no recorded information about whether the medication was suitable for this person. This left them at risk of harm from inappropriate treatment. The National Institute for Health and Care Excellence (NICE) in Managing medicines in care homes guidelines March 2014 recommends the policy should also include which people should not be given certain medicines or products.

People were not protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine storage arrangements at the home were appropriate and safe.

At our last inspection we found shortfalls in the recording of medication administration and there was no guidance for staff to follow for the use of 'as required' (PRN) medicines. People take PRN medicines only if they need them, for example if they experience pain. At this inspection we found MAR charts had been completed fully and signed by staff to show when medicines had been administered and by whom. At the time of this inspection nobody was receiving PRN medicines. However; there was policy guidance for staff to follow, if it was required in the future, at the front of the MAR chart.

Staff understood their responsibilities in relation to safeguarding people who lived at the home in order to protect them from the risk of abuse. They were able to tell us about different forms of abuse and what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us they would report to the most senior person on duty at the time. If concerns were related to the registered manager or the provider they would report to the relevant external organisations. Staff said they would always report things. One told us, "I would never just leave something." Staff were confident the registered manager would report their concerns appropriately. We saw there was safeguarding information available for staff throughout the home, this included telephone numbers for reporting. Staff told us they were not sure who the relevant organisations were but would use the information that was displayed around the

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Is the service safe?

home. One said, "If I had to report it myself I would follow what was on the noticeboard." Another told us, "I have the notes from my training, I can always refer back to them to know what to do."

Staff had a good knowledge of people's needs and risks and individual risk assessments were in place in people's care plans, these provided information for staff on how to manage identified risks. Risk assessments included, nutrition, pressure sore risk and falls. There were environmental risk assessments in place and these included using the stairs or accessing outside space. One person liked to regularly spend time outdoors and had been assessed as requiring support whilst outside. Throughout the day staff accompanied this person outside when they chose to go out, to ensure they were safe.

The home was clean and well maintained throughout. Regular health and safety risk assessments and checks were in place and these included regular gas, electrical and lift servicing agreements. There were regular fire safety checks in place. A fire risk assessment had been undertaken in June 2014 by an external organisation. Information from this assessment had not been taken forward and used to develop appropriate evacuation procedures. A fire evacuation policy was in place and this was displayed in the hallway. The information in the policy did not reflect the information in the fire risk assessment. This was discussed with the provider and registered manager for improvement. The registered manager contacted the external organisation for further guidance during the inspection.

The home was staffed 24 hours a day and there were local arrangements in place with another home in event Lebrun House had to be evacuated.

There were enough staff working at the home to keep people safe and meet their needs. Staff told us there was generally enough staff working and they had enough time to spend with people to meet their needs. The registered manager and staff told us staffing levels were assessed according to people's needs, if people's needs increased then staffing levels were increased accordingly. For example if anybody was receiving end of life care extra staff would be on duty to ensure everybody received the level of care they required. In addition to care staff there was a cook each day and housekeeping staff. Although staff were busy throughout the day they were not rushed. They attended to people's needs in a timely way and had time to spend with people. Staff told us, and records confirmed, there was a manager or a senior member of staff on duty each day. Staff were aware who was in charge of each shift. There was an on-call system for staff to contact in an emergency if required.

The provider and registered manager ensured staff employed were suitable to work at the home. The registered manager told us as part of the interview process staff were introduced to people at the home. She explained this gave her insight about the staff member's ability to communicate and interact with people who were living with a dementia type illness. Staff files contained appropriate information for safe recruitment. This included an application form with full employment history, references, the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults. Where further information was required, for example gaps in employment history, these had been explored and recorded during the interview process.

Requires Improvement

Is the service effective?

Our findings

Staff knew people well and had the skills to look after them. People approached staff when they needed support or assistance and staff responded to them appropriately. One person was observed speaking to staff and explaining she did not know what she wanted. Staff asked her if she would like to go outside to which she agreed she did. Visitors to the home told us staff looked after their relative well and understood what they wanted and needed. One visitor said, "If there's any concerns they will contact the Doctor or the district nurse." People and visitors told us the food was good and we observed people enjoying their meals and snacks provided. One visitor told us, "I sometimes eat here, the meals are very nice, just the right proportions." A visiting healthcare professional told us staff were very knowledgeable about people and their needs.

Staff did not always follow the principles of the Mental Capacity Act 2005 (MCA) and they did not demonstrate an understanding of Deprivation of Liberty Safeguards (DoL's).This act protects people who lack capacity to make certain decisions because of illness or disability. The safeguards ensure any restrictions to their freedom and liberty have been authorised by the local authority as being required to protect the person from harm. Staff told us people were able to make day to day decisions about what to wear or what to eat however they were unable to make bigger decisions for example in relation to where they lived or their finances. One person had recently moved into the home and assessments showed this person lacked capacity. There were no records to support discussions about whether this person's liberty had been restricted by admission to the home. Doors to the home were locked and people were unable to leave the home when they wished. Staff explained due to people's lack of capacity they would be unsafe to leave the home unaccompanied. However, there was no documentation in people's care plans to demonstrate the restrictions were appropriate for everybody.

Doorways to the stairs were locked; we were told this was because people had been assessed as at risk using the stairs. There were risk assessments in place however these did not include information about how the decision had been made not to let people use the stairs. The doors to bedrooms on the ground floor were locked. Staff told us the doors were locked to prevent people from entering other people's bedrooms. Some people remained in bed all day; there was no record of why the bedroom doors were locked and no evidence of individuals or their representatives being involved in the decision.

This meant where people did not have the capacity to consent the provider had not acted in accordance with legal requirements. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mental capacity assessments in place which determined whether people had the capacity to make decisions. These were reviewed six monthly. Consent forms were in place to show people agreed to have their photographs taken and receive care and treatment. Although people were not able to consent these had been signed by the person's relative which showed they were aware and agreed. We observed staff asking people's consent before offering any support, for example where they wanted to spend their time or what they wanted to do. Staff told us if people did not agree to something then it would not happen. One staff member told us, "People know what they like, we would never make them do something they didn't want to do."

Training records showed when staff had undertaken training and when it was next due. Some staff told us they received regular training and updates, others who had not yet received any training said they were booked onto a number of courses over the coming months, and we saw records to confirm this. This included safeguarding, infection control, moving and handling and dementia training. However, not all staff had received training updates in line with the providers policy. For example, training records stated staff were to receive training in relation to safeguarding and mental capacity every two years. Records showed that out of 22 staff 16 had not received this training. Staff were required to receive food hygiene and infection control training every three years, records showed out of 19 staff required to have the training 17 had either not received it or it had not been updated as stated in the training policy. Staff refresher training is an area that needs to be improved.

Staff told us and records demonstrated they undertook an induction programme when they commenced work at the home. This was based on Skills for Care which reflected the

Requires Improvement

Is the service effective?

standards that care staff need to meet before they can safely work unsupervised. Staff told us this gave them a good understanding of the skills they needed to look after people. One of them said, "I was new to care but I was given enough knowledge not to feel out of my depth." They told us they received information from the registered manager during their induction period, but had not received formal training. For example, one staff member explained, "I haven't received any training to use a hoist so I wouldn't use one but I would watch other staff." This staff member went on to say during their induction they had been taught how to support people with their mobility safely. We observed them appropriately supporting people to mobilise. Another demonstrated a clear understanding of safeguarding procedures which had been taught at their induction.

Staff received regular supervision. There were signed supervision agreements in place. These defined both supervisor and supervisee responsibilities and what each person wished to achieve through supervision. Staff said they felt well supported at by the registered manager and colleagues. One staff member said, "You can always go to the manager, we work together and support each other, staff and managers." Another staff member told us, "I feel I can speak to the manager at any time, I don't have to wait until supervision."

People were supported to maintain a balanced and nutritious diet. Records confirmed that people had their nutritional needs assessed and when risks were identified these were reflected within care documentation. For example, records were in place to monitor the intake of people who were at risk of not eating or drinking adequate amounts. People were weighed monthly so staff could identify anybody who was at risk of weight loss or malnutrition.

People were offered a choice of meals and this was done before each meal. A choice of hot and cold drinks and snacks were served and available to people throughout the day. People's dietary preferences were recorded in the kitchen and some information was in their care plans. The cook and staff had a good understanding of people's likes, dislikes and portion size. Food was offered accordingly. Pictorial menus were on display in the dining room, but these were not used at the time of the inspection. Meals were served in a way that reflected people's needs. We observed some people eating their main meal from a pasta bowl rather than a plate. Staff explained this worked well for these people. Where people required special diets for example pureed or fortified these were served appropriately.

Breakfast and lunchtimes were relaxed, sociable occasions. People who were able asked if they would like to come to the dining room for their meals. People chose where they wanted to sit and we saw evidence of people remaining within their friendship groups. Staff chatted with people as they served the meals and we observed people enjoying themselves. We heard people talking and one person commented the pudding was "scrumptious" other people at the table agreed. Meals were served in a way which encouraged people to eat together and people were able to eat at their own pace. Some people required prompting and reminding to eat their meals and staff supported them appropriately and with kindness. We observed staff sitting on chairs and maintaining eye contact with people. They spoke softly and asked if they would like more food or offered alternative choices.

People were supported to have access to healthcare services and maintain good health. Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP, district nurses, optician and mental health team. Healthcare professionals who told us the staff referred concerns to them appropriately when a need was identified. Staff told us about discussions they had with people's GP's to ensure they were receiving appropriate care. Staff were concerned about a person's skin integrity and a referral had been made to the local tissue viability team for an assessment of their ongoing needs.

Good

Is the service caring?

Our findings

There was a warm and friendly atmosphere at the home. Interactions between staff and people were caring and professional. For example, staff ensured they spoke to people in a way they could understand and continually offered people reassurance and support.

People were supported by staff that treated them with dignity and showed a real interest in their welfare and views. People and staff had conversations about topics of general interest that did not solely focus on the person's support needs. People were comfortable with the staff supporting them. They freely approached staff and chose to spend time in their company. People and visitors told us staff were caring. One visitor said, "They're very, very caring I cannot fault them." One person said, "They're nice people here." Another said, "We're well looked after." Visitors to the home told us staff knew their relatives well and treated them with kindness.

We observed that all staff including the cook and housekeeping staff were happy to spend time with people. All staff spoke with people in an open, inclusive manner. They asked about their well-being and responded to their questions appropriately. We observed people being treated as individuals and with respect. Staff spoke with people using their preferred name, they were attentive and maintained eye contact during conversations.

Staff had a good knowledge and understanding of people they looked after. They were able to tell us about people's care needs, personal histories, likes, dislikes and choices. For example, staff knew some people liked to move to a separate lounge after their lunch and they were supported to do this. We observed some people sitting around the dining table after breakfast. Staff explained these people liked to remain there until they had their mid-morning hot drink. We saw staff spent time chatting to people and ensuring there was nothing else they would prefer to do.

Staff understood the importance of providing care that was tailored to meet people's individual needs. They supported people in sensitive, pleasant way that did not rush people and supported them in a way that promoted their independence. One person was walking barefoot around the home. Staff asked the person if their feet were cold and would they like some socks or slippers to wear. The person asked for slippers and staff supported them to put their own slippers on.

Staff had a good understanding of the needs of people who were living with a dementia type illness and unable to express themselves verbally. One staff member said, "I watch people, I see how they respond, it's about observing people who can't explain what they want." Another staff member told us, "I know people's personalities, that's how I can tell if they are happy or if there's a problem." Staff explained knowing people well enabled them to provide the care people needed.

People were able to move freely around the home. There was lift access to the first floor and people who were able used the lift unaided, others were supported by staff. We heard one person telling staff they felt very tired, staff asked if they would like to rest in the lounge or return to their bedroom. Staff supported this person to return to their bedroom. We observed another person walking in the hallway staff asked the person if they were alright and then reminded them there were activities in the lounge. We observed this person taking part in the activities and they appeared to be enjoying themselves.

Some people remained in bed due to their health related conditions and general frailty. Staff told us the checked these people every hour. We observed staff spending time with these people, talking to them and ensuring they were comfortable. Staff told us one person enjoyed having a hand massage and they spent time providing this. Staff told us one person was unable to communicate verbally however they were able to understand how this person was feeling by their facial movements. One staff member said, "When she is looking sad I will rub her hands and talk to her, she likes that, I don't leave until she's happier."

People's dignity was maintained and they were offered privacy. Care plans informed staff to, 'treat people with dignity at all times.' We observed staff discreetly asking people if they required support with personal care. People were well dressed in clothes of their choice which were clean and well laundered. All bedrooms were single occupancy and personalised with people's own belongings such as photographs and ornaments. Bedroom and bathroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. Some people were unable to respond to a

Good

Is the service caring?

knock on the door therefore staff entered the room and spoke to the person to ensure they were happy for staff to enter the room. Staff told us they were able to tell from people's facial expressions if people wanted them to be present.

When people moved into the home staff spent time getting to know the person to assess their needs, choices and preferences and this was recorded in their individual care plans. Records confirmed that where people were unable to express their own choices and preferences this had been discussed with people's relatives or representatives. Where appropriate information about enduring power of attorney were recorded.

Requires Improvement

Is the service responsive?

Our findings

We observed staff offering people care and support and respecting the choices people made. There was an activities programme which staff supported people to take part in as they chose and we observed people participating and enjoying themselves. Visitors we spoke with told us they were not involved in care plan reviews. They said their relatives were well looked after and they were kept informed of any concerns or changes.

At the last inspection 20 July 2014 we asked the provider to make improvements to records because records did not accurately reflect the care and support provided. This was important to be able to confirm that people were receiving the care and support they needed. The provider sent us an action plan stating they would have addressed all of these concerns by November 2014. At this inspection we found there were still some areas in relation to records that required improvement.

Staff knew people well and had a good understanding of their care and support needs, choices and preferences. However, records viewed did not always reflect the care and support people received. Prior to moving into the home the registered manager carried out an assessment with people, and where appropriate their representative, to make sure the home would be able to provide people with the care and support they needed. When people were admitted further assessments, risk assessments, social and medical histories were completed. This information was used to provide care to people. Individual care plans were developed once people had made the decision to move into the home permanently. Staff told us this also gave them time to get to know people, understand their individual choices and preferences and how they liked to live their lives. When they moved into the home people, and where appropriate their representatives, had been involved in the development of their care plans.

There were daily activity routines in two care files viewed. This included what time people liked to get up, what they liked to do during the day and bedtime routines. However, one of these was not dated and the other was dated 2013. It was not clear if this information reflected people's current choices and needs. One person's care plan informed staff the person required assistance with personal hygiene and getting dressed however there was no further information to guide staff about how to deliver this care to ensure consistency.

Care plan reviews took place regularly. From discussions with the registered manager and staff it was clear that people and their representatives were involved in discussions and decisions about their care. However, this had not been recorded. This meant there was no documented evidence about how people's care needs had been identified or guidance provided for staff. One person was at risk of pressure sores and had a risk assessment in place. This did not inform staff the person had a pressure relieving air mattress in place, or the correct settings for the mattress. Staff were able to tell us what the correct setting was, how this was determined and when it was checked. This had not been recorded and did not provide clear guidance for staff to ensure consistency or demonstrate evidence that people's needs were met.

We were told accident forms were completed if people had a fall. Once completed these were signed by the registered manager to, identify any further action, and amend the care plan as necessary. We saw one accident form that had not been reviewed by a manager and daily records showed another person had fallen but no accident form had been completed. There were no personal emergency evacuation plans in place for people. This meant there was a lack of documented evidence that changes in people's care needs had been identified or actions taken to prevent a reoccurrence of an incident.

Care plans did not reflect the individualised care and support staff provided to people.

In some care plans there was information about people's lives before they moved into the home. This included people's family history, work, hobbies and interests. Not all records demonstrated discussions had taken place to provide people with an opportunity to continue with these interests. One person talked to us about a particular interest however this had not been recorded in the care plan and they were not now supported to pursue this interest.

People's personal records were not accurate and up to date. This is a breach of Regulation 20 of The Health and

Requires Improvement

Is the service responsive?

Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily records and other charts in relation to people's care and support were well completed and provided staff with good information about how people had been looked after.

People were not socially isolated and staff supported people to take part in social activities. Visitors told us they were always welcome at the home and could visit whenever they chose. There were signposts around the home to remind people where for example the lounge, dining room and toilet facilities were. This enabled people to maintain a level of independence as they were able to find their way around the home. There were a range of activities available for people. This included external visitors who for example offered gentle exercise groups, reminiscence sessions and visiting animals. Staff also provided some group activities and we observed people enjoying themselves playing a ball game. Staff encouraged and supported people to take part in the group activities. They reminded people what was available and talked to them about when they had previously taken part in the particular activity. Two people were able to tell us they enjoyed the group activities. We observed people participating and enjoying themselves in the activities offered.

Not everybody was able to take part in group activities but staff knew what people liked to do. One person enjoyed a hand massage and another person liked to look at magazines. Staff told us one person liked to go for a walk around the home during the afternoon. We observed staff checking this person was happy to walk on their own. Staff were aware that conversation and interaction were important activities for people. We observed staff sitting and talking with people either as individuals or as groups throughout the inspection.

Activities had been discussed at the last residents meeting in June 2014. People had discussed their hobbies and interests which staff told us would be used to develop further activities.

There was a complaints policy in place and this had been followed when complaints had been received. Where people had not been happy with the outcome of a complaint we saw the matter had been referred to the Local Government Ombudsman. The Local Government Ombudsman looks at complaints about organisations such as care homes and investigates complaints in a fair and independent way. Visitor's we spoke with told us they had no complaints but if they did they would be happy to raise them with staff. During the inspection people approached staff if they were not happy. For example, one person did not want to take part in activities, they approached staff who supported them to another room and spent time talking with them.

Requires Improvement

Is the service well-led?

Our findings

Visitors told us the registered manager was approachable and always available. A healthcare professional told us, "There's always a manager there, they really know what's going on and look out for people." Staff told us they felt well supported by the registered manager. They said she was approachable and they could talk to her about anything professionally or personally. Staff told us she would act on concerns appropriately. A visitor told us there was an, "open and transparent" atmosphere at the home. We observed people were relaxed and approached the provider and registered manager freely.

A registered person (provider or manager) must send notifications about the absence of a registered person for 28 days or more to the Care Quality Commission without delay. We had not been notified about an absence. This meant we did not have the opportunity to assess if there were appropriate arrangements in place for the management of the home during a registered managers absence.

This is a breach of Regulation 14 of The Care Quality Commission (Registration) regulations 2009.

The provider had systems in place for monitoring the management and quality of the home. This included environmental and health and safety checks, medication and care plan audits. Records showed the registered manager audited one care plan each month through a spot check and the deputy manager reviewed and updated five care plans each week. Medication audits had been completed monthly, these showed there were no shortfalls however we had identified there were no photos were in place for MAR charts and fridge temperature had not been checked.

An external consultant had undertaken an improvement plan dated June 2014. This highlighted the need for signage around the home to assist people to identify the purpose of each room, and this had been implemented. The improvement plan also identified the need to identify individual activities for people, which should include their past interests, this had not been addressed. There were no accident and incident audits to identify themes or trends across the home. Therefore areas for improvement were not always promptly identified or addressed. This showed us the systems in place to assess the quality of the service provided were not always effective. Audits had been completed incorrectly and areas where action was required had not been addressed.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager promoted an open and inclusive culture at the home. She told us she was aware of the day-to-day culture in the home as she worked directly alongside care staff and encouraged staff to talk to her openly. She spent time talking with people and engaging with staff throughout the day. We observed people and staff were comfortable approaching and talking with her. She had a good understanding of people's individual preferences and their care and support needs. We observed people coming to her office to discuss concerns or seek assurances during the inspection. A member of staff told us, "We're a team here, we work together and support each, staff and managers."

We were told the aim of all staff was to ensure people received high quality, personalised care in a homely environment. Staff told us, "It's about making it homely." Another staff member said, "We want people to be happy here." Staff acknowledged some of the records needed improvement. They told us, "We want to spend time with people, looking after them, supporting them, sometimes paperwork gets missed." This told us the registered manager needed to take steps to ensure staff were aware of the legal requirements in relation to completing care records.

Staff received supervision which supported them in their role and encouraged them to develop professionally. All staff were able to undertake further training for example Health and Social Care diplomas. We observed the registered manager supporting a staff member in relation to this. This supported staff to develop skills to improve their working practice. This showed the registered manager was striving to monitor and improve services for people.

We read the notes of a staff meeting. Staff had been reminded they could discuss any concerns they wished

Requires Improvement

Is the service well-led?

with the registered manager or provider. The notes went on to say if staff wished to raise concerns, but remain anonymous, they were able to do this for example by leaving a note. This showed us the registered manager worked with staff to promote a positive open atmosphere at the home. Staff told us they felt comfortable speaking freely at staff meetings and were encouraged to offer suggestions and ideas.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12(1)(2)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent the provider had not acted in accordance with legal requirements. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People's personal records were not accurate and up to date. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence The registered person had failed to notify the Care Quality Commission of the absence of the registered manager. Regulation 14 (1)(b)(3)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. Regulation 17(1)(2)(a)(b)(e)(f)