Bupa Care Homes (ANS) Limited

Market Lavington Care Home

Inspection report

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30 September 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Market Lavington Nursing and Residential Centre provides accommodation to people who require nursing and personal care. Some people have dementia. The home is registered to accommodate up to 87 people.

During the last inspection in March 2015, we found breaches to some of the legal requirements in the areas we looked at. Improvements were seen during this inspection which demonstrated the service had responded to our feedback and had implemented improvements in line with their action plan.

The inspection took place on 27, 28 and 30 September 2016 and was unannounced.

On the day of our inspection, there were 68 people living at the home within two separate units. The residential unit had people's bedrooms on the ground and first floor. There were two lounges, a separate dining room, bathrooms and toilets and a passenger lift to give easier access to both floors. The nursing unit had similar facilities but also contained the main kitchen and laundry facility.

A registered manager was employed by the service. 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 registered manager has worked at the home for approximately fifteen years. The registered manager was present for the inspection and the area manager on days two and three.

The ordering, storage and disposal of medicines was managed effectively. We observed two medicines rounds during the inspection. The administration of medicines was done in accordance with current guidelines and regulations apart from one occasion when, during one of these medicines rounds, a staff member had not consistently witnessed people taking their medicines but had signed the medicine administration records to confirm they had done this. This increased the risk as the member of staff could not be confident these people took their medicines when administered and at the prescribed time.

People told us they felt safe when receiving care. Staff were able to tell us how to recognise signs of potential abuse and what action to take if they had any concerns. People's risk assessments had been made and recorded in people's care files. Staff told us there was a culture of balancing risk whilst also not being too restrictive which meant people's freedom was considered in order to help them maintain their independence.

There were sufficient numbers of suitable staff to support people and safe recruitment practices had been followed before new staff members started working at the home. People who used the service and their relatives were positive about the care they received and said staff had sufficient knowledge to provide support and keep them safe.

Arrangements were in place for keeping the home clean and help reduce the risk and spread of infection. People's rooms and sanitary ware in bath and shower rooms were kept clean.

People were encouraged to make decisions and staff gained people's consent prior to carrying out any tasks. The service had a clear understanding on the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

Staff received regular training in relation to their role and the people they supported and told us this training supported them to do their job effectively. Staff received regular supervisions and an appraisal where they could discuss personal development plans. This meant staff received the appropriate support to enable them to provide care to people who used the service.

The documentation to monitor diet and fluid intake of people who were at risk of malnutrition and/or dehydration were not consistently completed. Staff told us this information was recorded in people's daily records but this was not consistently done. This meant people were at risk of dehydration and/or malnutrition.

People and their relatives told us they had access to health services and a GP performed weekly visits to the home with additional visits according to any changing healthcare requirements.

The registered manager and staff we spoke with were passionate about providing care which was tailored to people's needs and choices. People told us they were happy with the care they received and the way staff treated them. Throughout our visit we saw most people were treated in a kind and caring way and staff were friendly, polite and respectful when providing care and support to people. However, we observed some staff who were task focussed and sometimes did not converse with people they supported with their meals.

Staff understood the needs of people they were providing care for. Care plans were individualised and contained information on people's preferred routines, likes, dislikes and medical histories.

People, their relatives and staff were encouraged to share their views on the quality of the service people received and were informed of what improvements and changes had been implemented following their feedback.

People, their relatives and staff spoke highly of how the service was managed and as well as there being an open door policy, regular staff meetings took place to allow staff to voice their feedback and be updated on best practice.

There were systems in place to monitor and improve the quality and safety of the service provided. Where actions to improve the service had been identified, these had been acted upon.

We found a breach of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People's personal safety had been assessed and plans were in place to minimise risks.

Staff were knowledgeable in recognising signs of potential abuse and what to do if there were safeguarding concerns.

There were sufficient staff to support people's care needs and robust recruitment practices were followed before staff were employed to work with people.

Is the service effective?

Good

The service was effective.

People said they liked the food and there was varied menu on offer. People also had access to specialist diets when required.

Staff received the necessary training and had the right skills to meet people's needs.

Most people who needed support with making decisions were assessed to ensure their best interests were protected in a lawful way.

Is the service caring?

Good

The service was mostly caring.

People spoke positively about staff and the support they received.

Most staff were caring in their approach and had a good understanding of people's needs and how best to support them.

People's bedrooms were personalised and contained their personal belongings. People were able to choose where they wished to spend their time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and support plans were personalised and were reviewed regularly. However, the documentation to monitor people at risk of malnutrition and/or dehydration not consistently recorded.

People were supported to follow their interests and take part in social activities although people who chose to remain in their room or were cared for in bed were sometimes not offered the same degree of support.

People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously.

Is the service well-led?

Good

The service was well led.

Systems were in place to monitor the quality and safety of the service provided. Where actions to improve the service had been identified, these were acted upon.

Staff said the management team were approachable, and felt they could raise concerns and seek guidance.

Staff felt valued and supported by the management team and enjoyed working at the home.

Market Lavington Care Home

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 27, 28 and 29 September 2016. The first day of the inspection was unannounced.

Two inspectors and two experts by experience carried out this inspection. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.
The areas of expertise for the experts by experience during this inspection were end of life care and people with physical and learning disabilities.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.
During the last inspection in March 2015, we found breaches to some of the legal requirements in the areas we looked at.

We reviewed the 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 used a number of different methods to help us understand the experiences of people who use the service. This included talking with 19 people who use the service and six visiting relatives about their views on the quality of care and support being provided. During the three days of our inspection we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included nine care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, area manager and 13 staff including care staff, registered nurses, housekeeping staff and staff from the catering department.

Good

Is the service safe?

Our findings

At our last inspection which took place on 12, 14, 17 and 20 March 2015, the provider was not meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not consistently signed the medication administration records to show people had taken their medicines as prescribed and medicines had not always been safely secured. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection, that the provider had undertaken the improvements required to meet people's needs, however, there were some inconsistencies with administration systems.

We observed two medicines rounds; one in the residential and one in the nursing area of the home. There were good processes in place to ensure the safe administration of medicines. People were clearly identified on the medication administration record with details of their date of birth, GP and any allergies. All staff who administered medicines received training and received regular supervision to ensure their competency in administrating medicines. We did not see people self-administer their medicines but staff told us people were given the choice to self-administer and described how they would support people to do this. Staff were knowledgeable about the medicines they were administering and were able to explain to people what they were taking.

We observed one member of staff had signed for the administration of medicines prior to observing a person taking them and had left their medicines with this person in their room. When we raised this with the member of staff, they told us they trusted this person to take their medicines and this was the reason they did this and they did not do this for everyone they administered medicines to. This was not in line with current guidelines, legislation or with the provider's own medicines policy which stated 'The MAR must only be signed after the medication has been taken'. We raised this with this member of staff who said they would correct this practice with immediate effect. This was isolated to one member of staff. All other members of staff we spoke with were able to tell us how to safely administer medicines in line with the home's policy and this practice was not seen during the other medicines round we observed.

The ordering, storage and disposal of medicines was managed effectively. Medicines trolleys were kept secure and locked when not attended and medicines were stored in conditions as appropriate to the labelling. We discussed how medicines were ordered, stored, administered, recorded and disposed. We saw systems in place which included monthly audits for expiry of medicines and stock rotation. There were records for storage temperature of drugs and this was monitored and recorded on a daily basis. Staff knew what to do in the event that storage temperatures varied outside the acceptable levels.

Overall, the documentation of when medicines had been administered was done in line with current guidelines and legislation. However, this was not always the case. For example, the administration of topical creams and lotions was not consistently documented. There were body charts in place which showed the locations of where creams or lotions were to be applied but there was no clear documentation to show when this had been done. When we asked staff about this they told us this information could be found in people's daily records however, whilst the application of some topical treatments had been entered, there

were other times when this had not been done. One member of staff told us they were confident people were receiving their topical treatments as required as there was no surplus stock and resupply of stock was required within an expected duration.

At our last inspection which took place on 12, 14, 17 and 20 March 2015, the provider was not meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst people had looked well supported and were not waiting for assistance, there had been varying views as to whether there were enough staff on duty at all times and some people received little stimulation. One person had fallen without the awareness of staff. Staff had not been in the vicinity to give assistance and did not respond to the person's call bell in a timely manner. This had placed the person at risk of further harm. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection, that the provider had undertaken the necessary improvements required to meet people's needs.

Sufficient staff were available to support people. We saw people had access to their call bells and when used, these were answered promptly. We saw a log which showed how long it had taken for call bells to be answered. This showed call bells were answered promptly, and that none were active for more than five minutes. People told us they were able to access help whenever they needed it. Comments from people included "Yes they come quickly when I press my bell" and "I have a bell and I can ring and staff will come and help me. They come quite quickly when I ring".

We saw safe recruitment and selection processes were in place. We looked at the files for five of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Candidates were encouraged to visit the service before applying for employment. The registered manager explained this helped people have an insight in to the role and what was expected of care staff. New staff were subject to a formal interview prior to being employed by the service which included an interview assessment.

People told us they felt safe living at the home and they did not have "anything to be concerned about". Comments included "Staff were always around to help if needed and "If I wanted staff to help I can call for them". Relatives also confirmed they had no concerns about the safety of their family member.

Policies were in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken. Staff we spoke with could explain what keeping people safe meant. We saw from staff records that they had received training in safeguarding adults from abuse and whistleblowing. Staff knew the different types of abuse and said they were confident the manager and senior staff would act on their concerns. Staff were aware they could take concerns to agencies outside the service if they felt they were not being dealt with.

People were protected from the risks of potential abuse or harm. There were a range of individual assessments which identified potential risks for people. We saw that this information was documented for each person and included how to manage the risks including risk of falling, pressure ulceration and the safe moving and handling of people. One member of staff told us how they had assessed someone who was at risk of pressure sores and what had been put in place to help prevent this. We saw in one person's care plan, they had been assessed as being at high risk of developing a pressure ulcer. The action plan gave guidance on what could be done to prevent this which included having a pressure relieving mattress and regular

repositioning. When we looked at daily records for this person, we saw that they had received care in line with the care plan.

People were protected from the risk and spread of infection. Areas of the home were clean and tidy and there were systems in place to monitor that cleaning was done consistently throughout the home. Staff were also provided with sufficient personal protective equipment (including gloves and aprons) which we saw being used as appropriate during the inspection.

Good

Is the service effective?

Our findings

At our last inspection on 12, 14, 17 and 20 March 2015, the provider was not meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. We found that whilst a range of training courses had been in place, not all staff felt the delivery of subjects was conducive to their learning and some staff felt they wanted more training in key subjects such as end of life care and dementia. Not all staff had felt supported in their role. The frequency of formal one to one supervision had not been consistent with sessions predominantly focussed on information sharing rather than the staff member's performance and well-being. In addition, documentation in people's care records had not always demonstrated a clear understanding of the legislation of the Mental Capacity Act 2005. Staff had not assumed capacity which was integral to the legislation and best interest decisions had been made without clear assessments of capacity. The provider wrote to us with a plan of actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken the necessary improvements required to fully meet people's needs.

Staff received regular training to give them the skills to meet people's needs, including an induction and training on meeting people's specific needs. The registered manager had systems in place to identify training that was required and ensure it was completed. Training records confirmed staff had received the core training required by the provider, such as safe medicines management, safeguarding, the mental capacity act, infection control, manual handling and health and safety. Nursing staff received training appropriate to their role which included tissue viability, syringe driver and end of life training.

New staff received a comprehensive induction which included shadowing more experienced members of staff before working independently. Staff attended a five day induction programme which included classroom based training, completing a workbook and observing the working practices of other staff members. The workbook they completed covered areas of their responsibility such as pressure ulcer care, working in a person centred way, equality and diversity and safe moving and handling practices. Once staff had attended this programme and completed the workbook they would be signed of as being competent by the registered manager.

Records we looked at confirmed staff received regular supervision sessions and annual appraisals with their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had.

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 legally authorised under the MCA. 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). The registered manager and staff acted in accordance with the requirements of

the Mental Capacity Act 2005. Consent to care was sought in line with legislation and guidance. Mental capacity assessments had been completed and where people had been assessed as not having capacity, details of best interest decisions had been documented. Where required, Deprivation of Liberty Safeguarding applications had been submitted to the appropriate authority by the registered manager. During the inspection we saw staff seeking consent from people prior to carrying out tasks. For example, asking whether they would like their food cut up and when they would like to get up in the morning.

We observed the lunch time meal for people on two days. People said they enjoyed the food and drinks were available to them with their meals. One member of staff told us people were always given a choice and said "If the residents do not like anything that is provided from the main kitchen we try our best to give them an alternative". There was a varied menu on display and we saw staff explain the menu to people and gave them the opportunity to choose what they would like. Comments from people on the food included "The food is delicious" and "I enjoyed today's lunch – if there is something I don't like then I can ask for something else". One person's relative told us "The food always looks good. There are always drinks available; tea coffee and cold drinks". When we spoke to the catering staff, they told us they had information on people's likes and dislikes as well as any specific dietary requirements. People had access to specialist diets when required for example, pureed or fortified food.

People were supported to maintain good health and had access to healthcare and other services to meet their needs. There were records of treatments relating to chiropody, eye care and GP and nurse visits and appointments with other health care professionals. For example, we saw in one person's care plan it had been identified they were at risk of choking. In response to this, a referral for speech and language therapist had been made and steps were put in place to reduce their risk of choking.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the care and support they received from staff. Comments from people included "The staff are all very helpful and kind. They are all very good here", "Before I moved here things about the home where explained to me and I had the opportunity to say what care I wanted" and another person told us staff were always "cheery" and would often have a joke with them. One staff member told us about a person who loved singing and that they used to ask them to sing to them. As they enjoyed singing to music the staff member had suggested the use of a CD player so they could sing along to this whenever they wanted and now regularly enjoyed doing this.

Whilst the majority of staff interactions with people were kind and caring, we did observe some interactions which were not as positive. This was mainly when staff were supporting people with their meals. On one occasion, when a staff member had finished supporting a person with their meal, they got up and left without saying anything. This staff member then entered a second person's room and whilst they asked if the person wanted a pudding and explained what it was they then proceeded to feed this person in silence. They did not verbally ask if the person was ready for the next mouthful or if they were okay during this assistance. On another occasion we saw a staff member leaning on the back of a person's chair without seeking their permission and having no interaction with them.

We saw other staff supported people in a caring, kind and friendly way and we observed some positive interactions on both days of the inspection. For example, one person becoming anxious as they were unsure where they were. Staff crouched down to speak with the person and took the time to explain where they were and offered reassurance. They stayed with the person until they received their lunch and were settled. We observed one staff member having a pleasant conversation with a person who had been showing signs of anxiety. This staff member talked about a picture on the wall. They engaged this person in the conversation by asking them whether they had been to the place shown in the picture, explaining where it was. The person began to reminisce about visiting there and became more settled.

We observed staff knocking on people's doors before entering their bedroom. Staff were able to tell us about the importance of respecting people's rights to privacy and dignity. One staff member told us how they ensured people's dignity was maintained during personal care; how they shut doors and curtains, and covered people whilst assisting them to wash and dress and asking for their permission prior to assisting them. People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included items such as ornaments, photographs and their own furniture.

Staff offered people choices and involved them in making decisions about their care, treatment and support. For example, staff supported people to access the dining area asking where they would like to sit. Adapted crockery and cutlery was available to support people and help them be independent. In one person's care plan, it stated they preferred to have a shower. A staff member confirmed this and said they have a shower as this was their preference. In another person's daily records it stated their preferences with regards to their wish to stay in their room during the day. Their records also showed that although it was this

person's choice to remain in their room, staff still sought advice from this person to determine this was still their wish. Their daily records on one day stated "X still prefers spending time in her room and is happy for staff to pop in for a chat'. Another staff member told us they get to know people's preferences, interests and hobbies, and because of this, they are also able to support people who may no longer have the capacity to ask for what they want. People had memory boxes outside their rooms with items and photographs they could reminisce about. Staff said this also helped people orientate where their room was.

Staff told us they supported each other and worked well together. One staff member told us they enjoyed working at Market Lavington and that there was always a friendly atmosphere. They told us one of their favourite things was talking to people and their relatives and being able to provide them emotional support.

Staff also told us how they cared for people during their end of life. They told us how they would ensure people were comfortable, for example, carefully repositioning them, providing pain relief as required, giving them mouth care and spending time with them as well as providing support for their relatives.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 12, 14, 17 and 20 March 2015, the provider was not meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. Planning and delivery of care had not always been done in such a way to meet people's individual needs and ensure their safety and welfare. Care charts had not consistently been completed which did not enable effective monitoring or provide evidence that people were being properly supported. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken improvements regarding the completion of charts to monitor when people were at risk of developing pressure ulcers and care plans gave guidance on how often to do this.

People's care and support plans were personalised and were reviewed regularly. Care plans included details of the support people required and what they were able to do independently. For example, in one person's care plan, it stated they preferred to select their own clothing but due to this person's condition, they were at times unable to select the most appropriate clothing for the type of weather. A staff member confirmed this and told us they enabled this person to choose what clothes they would like to wear and staff would then support them if this was not appropriate i.e. if they needed to wear a jumper they would help them with this.

However, the food and fluid intake of people at risk of malnutrition and/or dehydration was not always consistently recorded. Although people had their weight measured and documented monthly as a routine, and more frequently if there were concerns regarding weight loss, people who were at risk of malnutrition and/or dehydration did not have their diet and fluid intake sufficiently monitored. For example we noticed a person who had their meal in front of them which was untouched. This person proceeded to push the food with his fork but did not eat anything. Staff came along with tea trolley and tried to encourage him to eat but he declined his meal and staff took it away. On no occasion did the staff offer them an alternative, or try to investigate why they refused their meal. When we looked at this person's care plan, it stated they needed their meat cutting up which it had not been nor any other food they had been given. When we looked at their daily notes later that afternoon, it had not been recorded that they had not eaten their lunch. The same person had been having their weight monitored although records on monthly weights were inconsistent. For example, there were two different weights recorded in September which were substantially different, one being recorded as 74.4kg and the other 66kg. This meant it was not clear whether this person had lost weight from a previous recording in August which showed their weight to be 78.5kg. On 10th August 2016 this person's care records stated they 'continue to lose weight slowly'. There was no evidence of any actions taken in response to this. When we asked staff about this person's food intake, they told us this was not being monitored and referred to him as having a healthy appetite. This meant there was a risk this person may continue to lose weight and not be supported appropriately in response to this.

The care plan for another person stated they required their food and fluid intake monitoring. There were entries in this person's daily notes stating they had drunk 275mls plus a few sips of fluid and half their lunch and one yoghurt in the last 24 hours. When we asked staff how food and fluid intake was monitored and recorded they told us this was recorded in people's daily records but the way in which the fluid intake had

been documented for this person did not give a clear indication of how much fluid they had consumed. In addition, this person's mouth looked very dry but nothing had been documented to state this person had received oral care to help make them more comfortable. When we asked staff when they would consider using a food and fluid chart to monitor how much people were eating and drinking, they told us these charts would only be implemented if they were "very concerned", for example when someone was losing weight. Although staff were able to tell us how they would assess people's risk of malnutrition, the lack of documentation in care records being used to monitor this risk meant people were at risk of losing weight and becoming malnourished before necessary steps to prevent this had been implemented.

This was a breach of Regulation 12(2)(a) Safe care and treatment of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to them moving into the service and care and support plans developed in line with this information detailing a person centred approach. Care plans details people's preferences, likes, dislikes and routines. This provided staff with clear and detailed information to guide them on how to respond to ensure people's care needs were met in their preferred way. For example, it stated in one person's care plan they liked to have a routine and their personal items kept in a specific place or order which gave them a sense of security. When we spoke with staff they confirmed their knowledge of this. There was also documentation in this person's daily records that confirmed this.

People were supported to follow their interests and take part in social activities. Care plans detailed people's choices on what activities they would like to do and were detailed in a 'my day my life portrait'. This included details on any difficulties with communication such as sight and hearing loss, how these could be overcome and what sort of day to day activities they would like to be involved in. On the first day of the inspection we saw a person who was leaving to attend a weekly art club. People and their relatives told us they were always made very welcome and there was an 'open' visiting policy. Photos of recent activities were displayed in the communal areas of the home. These showed people enjoying activities such as a zoo visit, social evenings and special events. Books, magazines and daily newspapers were available and in one communal lounge area a book of photos which detailed information about the location of the home called 'where we live'. There were two activities coordinators in post who arranged various activities including trips to the local market, singing, tea parties, quizzes, gardening and games. People were also offered a church service from the visiting clergy. People and staff told us about a recent activity where people were given seedlings to plant and these had been placed in pots at the front of the home. Staff said people had enjoyed watching their seedlings grow and establish into a display of flowers they could all enjoy. These were seen on display during the inspection. During the inspection we observed a quiz where each person spoke about themselves and their earlier lives. One person told us at the end of this activity "I really enjoyed the quiz and going down memory lane."

Staff told us people who were unable to join in group activities, for example, if they were being nursed in bed, would be offered other activities, such as having magazines, books or poems read to them, looking through old photos, having therapies such as hand massage or simply having one to one chats. However, the people cared for in bed or who wished to stay in their bedrooms were not offered the same variety of activities. We were told during the inspection staff would chat to people who stayed in their rooms during support with personal care, when drinks were taken to them and when they had their rooms cleaned but when this occurred we observed interactions to be very brief and there was no clear dedicated time observed where staff would go and sit and spend time with these people. During the first two days of the inspection, activities coordinators were not on duty and despite staff telling us they had time to support people and had time to sit and chat, people who chose to remain in their rooms or were nursed in bed were not offered the same degree of support. This placed these people at risk of social isolation.

One to one activities were documented in an activity log in people's care plans although these showed very few one to one activities were taking place. On one occasion, we observed there were two people sat in a lounge area with four members of staff present. One member of staff was helping one person with their knitting. Another member of staff was supporting a person with a quiz and another tidying a few things up in the area. However, one of the care staff did not participate or interact with the group or make any attempts to speak with people. Two members of the same group of staff then left the area and sat at the nurse's station. Both staff did not engage in any activity whilst being sat at the nurse's station and as we had observed people being alone in their rooms this was a missed opportunity for them to offer to spend some time with them. There was more than one occasion that we saw staff sitting in a group in this area where only two or three people were sat.

People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously. Their comments included "I have no grumbles. If I am not happy with something I will say" and "The staff are all very friendly. I can say if I am not happy with something".

The registered manager had a log of compliments and concerns they had received prior to our inspection. There was a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. All had been resolved to people's satisfaction. There was information on how to make a complaint available to people and their relatives posted throughout the home.

The provider valued people's feedback and acted upon their suggestions. Residents and relatives meetings were held throughout the year. Following these meetings a list of actions would be drawn up and compiled in a 'What you said, what we did' list which was posted in various communal areas throughout the building. For example people had asked to have local papers made available and we saw these had been purchased. People had requested more savoury snack options and these were now available on the tea trolley between meals.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was available throughout the inspection. There were many positive comments about the registered manager and staff team. Staff said they enjoyed working at the service. One member of staff told us "I do have niggles from time to time, that is natural. But I let all these go over my head because I love my job, and think about the people who live here as one big family".

The registered manager interacted positively with people who lived at the home and knew the staff well. All the staff we spoke with said they had regular one to one time with the management team. They said this was helpful in their development and they had the opportunity to take further vocational qualifications.

The registered manager told us about how they worked with staff to help them progress their career development. They said the staff felt confident in making suggestions and sharing new ideas. For example, they told us about one member of staff who had suggested holding a Christingle service as they had felt people might like this and staff had also requested more medicines trolleys to make it easier to administer administration around the home. These ideas were implemented and we were told had worked well. Staff told us the registered manager was approachable and encouraged them to report concerns. These staff said they had regular staff meetings where they were able to express their points of view and as the registered manager operated an open door policy they could address their concerns at any time.

The service had effective systems in place to monitor the quality of the service being delivered. Audits were carried out periodically throughout the year the by the registered manager and a care and quality team within the organisation. This covered the management of medicines, infection control accidents and incidents, call bell timing analysis and care planning. Where issues had been highlighted, actions had been put in place to address these.

The maintenance of the home was managed well and included regular servicing and property safety checks to ensure people were safe. This included regular fire alarm testing and gas, electric and water inspections. Servicing of equipment was also completed and recorded to ensure it was fit for purpose. The service also had appropriate arrangements in place for managing emergencies including contingency plans in the event of a fire or loss of utilities.

The registered manager managed the staff roster depending on people's needs and number of people using the service. Permanent staff covered most unplanned absences and agency staff were very rarely deployed. Regular relief staff were employed at the service to cover shifts when required.

The registered manager told us that they networked with external services and organisations. They also attended regular manager meetings with other home managers within the organisation. This gave them the opportunity to share best practice and also seek support and guidance from other home managers which they said they found very useful. They also had contacts of advocacy services and although we were told people were offered these services none were currently being used. There were regular staff meetings, which were used to give the opportunity for staff feedback, share best practice and keep staff up to date. Actions

raised during these meetings were implemented and documented accordingly.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was insufficient documentation to monitor people who were at risk of malnutrition and/or dehydration. Regulation 12 (2) (a).