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Snydale Care Home

Inspection report

Snydale Care Home
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7 January 2016 and was unannounced. The home was last inspected on 29 October 2013 and was found to be compliant in all the areas We looked at.

Snydale Care Home provides residential and nursing care to older adults some of whom live with dementia. The home has two floors with a passenger lift from the ground to the first floor. The home does not have units specifically for people living with dementia.

The home did not 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 registered manager left in November 2015 and was in the process of applying to de-register as the registered manager. There was a new manager in post and they were in the process of registering with the CQC.

People were protected against the risk of abuse because staff had received training in recognising the signs of abuse and knew how to raise their concerns. Staff were aware of the whistleblowing policy.

Not all people who used the service felt there were enough staff to meet their needs in a timely manner. Staff felt there were not enough staff to support people at the busier times of the day. Visitors to the service felt there were not enough staff. The manager told us they were fully staffed and there were enough staff to meet people's needs. However they thought the way staff were allocated during the shift needed to change to be able to meet people's needs.

People were protected against the risk associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the safe storage and disposal of medicines. However, we found the recording of medicine administration was not consistent. We found not all medicines administered by staff had been signed for.

Recruitment practices were robust and staff confirmed they had received a period of induction. However not all staff we spoke with felt they had received the training during their induction for them to be confident in working alone. We saw staff received supervision.

Infection control procedures were followed. Staff told us they had a plentiful supply of aprons and gloves.

The new manager had a good understanding of the legal requirements of the Mental Capacity Act 2005 (MCA). However, staff we spoke with did not have a thorough understanding of how the MCA impacted upon their work and the need to protect the rights of people who may lack capacity.

We saw a well- balanced diet was available for people and people's nutritional needs were assessed. The

manager ensured referrals had been made to the appropriate health professionals when they needed support with their healthcare.

The manager had systems in place to monitor the quality of the service. Monthly checks and audits had taken place and covered all aspects of service provision. However the examples of deficits which we found in compliance with the regulations had not been picked up through these quality assurance processes

We found five breaches of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the full 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.

Staff had up to date training in safeguarding. This showed that staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

People were protected from the risk of harm because staff had the skills and knowledge to administer medicines in a safe way. However, not all the medicines administered had been signed for by staff.

People were protected from the risk of harm because the provider completed a series of pre-employment checks prior to being confirmed in post.

There were effective systems in place to reduce the risk and spread of infection.

There were not always enough staff on duty to meet the needs of people in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training in the Mental Capacity Act (MCA) 2005. However, the service did not always follow the principles of the MCA by not assessing people's capacity to make a decision and there was a risk people were being unlawfully deprived of their liberty.

Staff received training on a regular basis and had the skills and knowledge to carry out their role effectively. However, some staff told us they had not received training during their induction. This meant there was a risk people were being supported by staff who potentially did not have the correct skills.

People enjoyed the food and felt there was plenty of choice available. People had access to a variety of snacks, hot and cold drinks through the day and with their meals.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respect. It was clear staff had a good understanding of how to support people and people who used the service told us they felt cared for.

Some people were not involved in the creation of their care record and did not know what a care record was. Other people were able to talk to us about their record and how staff consult with them about their support needs.

Staff had training in dignity and told us how important it was to ensure people's dignity was maintained at all times.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care records we looked at had gaps in information and there was a risk people's support needs would not be known by staff who did not know the person well.

The handover notes were detailed and each staff member had a copy of the notes during their shift. This ensured they had information on hand to support people.

People's changing health care needs were responded to appropriately. This meant people's health was being closely monitored.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in place although the new manager had started the registration process with the Care Quality Commission.

There were systems in place to monitor the quality of the home,

however the examples of deficits which we found in compliance with the regulations had not been picked up through these quality assurance processes

The manager was visible in the home and people who used the service and staff felt the manager was approachable

Snydale 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 7 January 2016 and was unannounced. The team was made up of one adult social care inspector, a bank inspector and a specialist adviser who was a qualified nurse with experience in medicines.

Prior to the inspection, we contacted the local Health watch team and the local authority responsible for monitoring the contracts with the provider. There were no issues highlighted as a result of our consultations. Health watch is the consumer champion for health and social care. They have the statutory power to ensure the voice of the consumer is heard by organisations such as the CQC who regulate health and care services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider to complete a PIR.

We spoke with one nurse and seven care assistants, one activity co-ordinator, the new manager, two relatives, a trainer from an external company and a health care professional. We spoke with five people who used the service

We looked at five people's care records and case tracked eight records specifically to review to the use of bed rails. We looked at the files for four staff members, the staff rota, the supervision matrix, training log and hand over sheet. We looked at all the audits and checks carried out by the home including complaints. Accidents and incident logs, medicine administration charts. We looked at the health and safety checks, including fire safety checks and water temperature charts.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. One person told us "I enjoy living here and feel safe." One of the visitors we spoke with felt the person they visited was safe at the home.

Care staff we spoke with had received training in safeguarding, they understood the different types of abuse people in the home might be subject to and had an awareness of the type of signs which would alert them to potential abuse such as a change in people's personality and behaviour in general. Staff knew where to find the safeguarding policy and felt the manager would act appropriately if alerted. We looked at the training matrix and saw training in safeguarding was up to date.

People we spoke with and their visitors told us there were not enough staff. One person who spent most of their time in bed in their room told us, "When I ring the bell, staff often came within seconds but sometimes came to ask what I need, then said they would come back soon because they were busy." We asked them if they felt this had an impact on how long they had to wait and they told us they did not worry about the length of time they had to wait. Visitors we spoke with told us, "At times there are not enough staff and this can have an impact, people can't go the toilet when they need to. The mornings are not too bad but there are not enough in the evening." Another person told us, "I do have to wait for my bell to be answered but I have never had any accidents or anything like that. Staff are very busy."

Both the care staff we spoke with said there was not enough staff. One staff member said, "We are one short today, but even with seven of us we haven't enough time to spend with people poorly in bed. We do give proper care but are often rushed."

The manager told us the usual staffing levels for a shift was one nurse with six care staff during the day and one nurse with four care staff at night. The manager told us the number of care staff on duty during the day had recently been increased to seven and they hoped this would address some of the issues with low staffing levels. The new rotas we looked at had seven staff on duty during the day. The manager told us if they were short staffed they asked their own staff to work extra hours but sometimes agency staff were used. The manager told us they used the same agency staff as much as possible but acknowledged this was not always possible.

The manager told us historically the allocation of staff was based on the need of the individual. Originally people whose needs were primarily nursing would be assessed as being more dependent on staff support so more staff had been allocated to the nursing unit. The manager recognized the needs of people living with dementia were just as high and this had impacted upon the allocation of staff. This was supported by one of the care staff we spoke with who told us, "Residents with memory problems now need more attention and supervision than we can give."

During the inspection, we did not hear the call bells ringing for long periods of time. However during our observations in the lounge, we saw there were times of up to five minutes when no staff was available for people. One person was shouting out for a member of staff and resorted to banging on their table to attract

the attention of the staff. Staff did respond to the shouts of the person after five minutes.

These are examples demonstrate a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The care staff we spoke with were aware of the whistleblowing policy and gave us an example of when they might us the policy. For example, letting the manager know when another member of staff acted in an unprofessional way. When prompted they told us if they were unhappy with the way the manager responded or acted, they would contact outside agencies such as the local safeguarding authority.

In the care records we looked at we saw a range of risk assessments used to monitor the care of people who used the service. The risk assessments included; manual handling, Malnutrition Universal Screening Tool (MUST), Waterlow scores to assess risk of development of pressure ulcers and falls risk assessments. This showed staff took steps to minimise the risk of harm to people who used the service.

We asked care staff whether there was enough equipment, such as hoists and slings for the safe moving and handling of people. One care staff we spoke with told us the home had four hoists which was enough but that one or more was often broken. On the day we visited they said two hoists were available. Staff felt this did not have an impact on the support people received. Both care staff told us said there were plenty of slings, of different sizes and slings were only used for one person before being washed. One person who used the service told us, "I have to go in the hoist when I need to get out of bed to the chair and I feel safe when staff use it [hoist]."

When staff administered medicines to people who used the service we observed staff knocked on people's bedroom door and waited for permission to go into the room. We saw staff were respectful and allowed time for people to take their medication and answer any questions people had. When administering specific types of medicines such as eye drops we saw staff washed their hands before and after administering the eye drops.

We looked at the controlled drug (CD) register and identified two occasions where staff had not recorded the time the CD had been given and one occasion administration of the CD had not been recorded. There was one occasion where the second signature was missing. We brought this to the attention of the manager and they told us they would address this with staff. We checked the stock of the CD's that had been administered and saw they reconciled with the amount in the CD register.

Staff who administered medicines talked us through the process for ordering and receiving medicines and how medicines were disposed of. We looked at the monthly audits of medicines carried out by the service. We noted there was no formal means of action planning following audits. Staff told us a new system was going to be implemented which ensured action plans from the audits were completed and monitored. Staff explained the process for recording drug errors.

Staff who administered medicines had the appropriate training and had competency assessments. This showed people who used the service were protected from the risk of harm because the service took steps which ensured staff were trained in the safe administration of medicines.

Some people had their medicines crushed and administered via a PEG feed. The care staff told us the effect of the medicine was not altered when it was crushed. The crushed medicine was not being given covertly and staff administering the medicines told us the General Practitioner (GP) had authorised the crushing of

the medicine.

Washbasins and toilets were clean and stocked with liquid soap and paper towels. We saw there was a plentiful supply of gloves and aprons. Staff we spoke with were aware of the infection control policy and thought the service had a good supply of gloves and aprons for them to use.

As we walked around the building we noted a malodour in two of the bedrooms. We asked the manager about this and they told us they were aware of the malodour and were in the process of changing the carpet in the bedrooms to see if this addressed the malodour.

During our walk around the building we saw a safety gate in place on top of some stairs which was also a fire escape route. We asked the manager whether the safety gate would prevent the safe evacuation of people. They told us they would check on this with the fire service and would let us know. After the inspection, the manager contacted us to let us know they had recently had a fire inspection from the West Yorkshire Fire Service and they told the manager if the stair guard was included within the fire risk assessment they were happy for the safety gate to remain in place. We looked at the fire risk assessment and saw staff had received training in releasing the bolt of the safety gate in the event of an evacuation.

We asked the manager why the stair gates were in place. They told us. "The purpose of these [stair gates] are to help prevent confused residents from accessing the stairwell and to stop them falling on the stairs." However, we noticed the guard rails did not always lock and when they were locked people could easily lean over the rail and unlock the rail. This meant people could access the stairs at any time. However, as we looked at the accident records, we could see no evidence people had fallen on the stairs.

We looked at the files for four members of staff. We saw recruitment and selection of staff was robust and effective. There was evidence in each record the service had requested and received two references, had held interviews and carried out pre-employment health checks. We saw a Disclosure and Barring Service (DBS) check had been carried out. The DBS enables organisations make safer recruitment decisions by identifying potential candidates who may be unsuitable for certain work that involve adults. We saw nurses had an up to date Personal Identification Number (PIN). To be able to work as a trained nurse in the United Kingdom you must register with the Nursing and Midwifery Council (NMC). The NMC is the regulator for all nurses and without a PIN number nurses are not allowed to practice.

Requires Improvement

Is the service effective?

Our findings

One person who used the service told us, "It's very safe here, the carers all know what they are doing." Another person told us, "Staff have the skills and knowledge to look after me." One of the visitors we spoke with told us, "Staff are skilled and knowledgeable."

There was a mixed response from staff regarding their training during their induction. One member of staff told us said they had received an induction which included training and shadowing an experienced member of staff before caring for people alone. Another care staff told us they did not receive any formal training during their induction of before starting to care for people. In the staff files we looked at we saw they had received a period of induction and training.

We looked at the training matrix for staff and saw training came in a variety of subjects such as dementia awareness, safeguarding, infection control and moving and handling. One member of staff told us they had previously worked with people who lived with dementia and received training in dementia care and had since completed a certified course in caring for people living with dementia.

One staff member told us training provided by the service was good and every six months they would attend a whole day's training on health and safety, safeguarding, DOLS, moving and handling and fire safety. Another member of staff told us," Training is good and constant." They told us they had completed a half day training course in caring for people living with dementia and were part way through completing the accompanying workbook.

We spoke with an external professional who told us they had observed lots of good practice at the home. They told us they had seen staff work with people safely when using hoists and supporting people when mobilising. They felt staff had the skills and knowledge to carry out their role efficiently. We saw staff carry out their role effectively and used the hoist safely.

Staff we spoke with told us they received supervision about every six months and an annual appraisal. Staff told us they were encouraged to suggest training needs: they had asked for palliative care training and it had been arranged for the near future. They told us the managers were very open to new ideas.

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 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 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

The training matrix showed not all care staff had received training in the MCA and the Deprivation of Liberty Safeguards (DoLS). Whilst staff could demonstrate they understood the need to gain consent while

delivering day to day personal care they did not have a good understanding about what the implications a lack of capacity to consent might be. One staff member told us if a person lacked capacity to consent, their family could make decisions for them. We asked staff what they would do if people refused personal care. One member of staff told us when some one refused personal care, they would ask another member of staff to try and encourage the person. In cases where people refused all offers of support with personal care, staff told us they would inform a senior member of staff and document the incident in the care record of the person involved.

Care staff we spoke with did not understand the test for mental capacity although one care staff knew the names of people who had a DoLS in place. Another staff member we spoke with thought everyone living at the home had a DOLS and that 'about half' the people living there lacked capacity.
We looked at the care records for eight people who used the service. In the care records we looked at we did not see any assessments of mental capacity. In one care record we looked at the person was living with dementia and their care plan stated 'does not have capacity.' There was no evidence in the person's care record to show how the provider has come to this conclusion. We saw four people who had bed rails in place did not have a corresponding risk assessment and in the other four care records there was no evidence mental capacity assessments had taken place. A senior member of staff we spoke with told us they did not undertake capacity assessments or consider consent for the use of bed rails.

These are examples demonstrate breach of Regulation 11 (1) (3) of the health and Social Care Act 2008 (regulated activities) Regulations 2014.

The manager told us they had a good understanding of their role and responsibilities in relation to protecting people's rights. They had made applications for a DoLS when people lacked capacity to make a decision for themselves and were deprived of their liberty in order to keep them safe. We saw the DoLS applications made were detailed with the expiry date noted. However this was not consistent because we noted one person spent a good part of the day walking around the building and at times went up to the door to the garden and asked to go home. At this point, staff intervened and distracted the person away from the door. We asked the manager whether a DoLS was in place for this person. They told us because the person was on respite a DoLS application had not been made. We asked whether the person could make a decision to go back to their own home. They told us the person was living with dementia and lacked capacity to make that kind of decision. However, there was no evidence in their care records to show how the service had come to that decision. This meant people who were on short stay placements did not routinely have a DoLS assessment and were being deprived of their liberty. We discussed this with the manager. They told us they had been advised by the local authority MCA team not to send in DoLS applications for people who are on short stay placements of seven days or less.

None of the DoLS applications made reference to the safety gates at the top and bottom of the stairs. However, the gates were easy to open and people did have free access to all floors of the home. The manager told us the aim of the gates was to ensure people who had poor mobility did not have access to the stairs unless they had support from staff and minimise the risk of people falling.

These examples demonstrate a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The care staff we spoke with told us the food was always very good. People were given choices at each meal, with alternatives written on a chalk board. Some people had been assessed by a speech and language therapist (SALT) and they had recommended a soft diet. We saw the chef had recorded people who were on special diets such as soft diets, gluten free diets or were diabetic on a chart in the kitchen. This ensured

kitchen staff could prepare the appropriate food for people to eat.

People who used the service told us the food was very enjoyable. They told us if there was nothing on the menu they wanted, they could ask for an alternative and this would be prepared for them. One person told us, "I didn't like the food yesterday so asked for a jacket potato and cheese and that is what I had." We saw a variety of snacks was made available day and night that included fruit, yoghurt, cake, biscuits and cereals. We saw people had a choice of where they wanted to eat their meals. There was a dining room and a large table in the lounge. People could also eat their meals in their rooms if they preferred.

We made observations over lunchtime in the main dining room. People came into the room and sat at tables. They were offered two meal choices which were served, as requested, with a cold drink. We saw that one person initially said they did not want anything and staff encouraged them to have a small portion which was served in a small dish. This helped the person not to feel overwhelmed by a large portion of food. Most people finished the meal served to them and then had pudding. A member of staff remained in the room during the meal. There was a calm atmosphere in the dining room and people were not rushed to finish their meal.

We saw other staff came and collected trays of food which were served to people in their bedrooms or another communal area. Staff told us six people needed one to one support to eat and drink. We saw care staff support people to eat their lunch. They sat down next to the person and offered food at a rate which suited the person best. We observed staff did not rush people and offered drinks during the meal. The meals looked nutritious and there was plenty of food on the plate.

The care staff we spoke with told us people were weighed each month. If people lost weight, they were referred to the dietician and weighed weekly. During the inspection we met with a community dietician who said they regularly visited the home. They said that referrals were appropriate and timely. They were happy with the care people received in the home. They said staff were helpful when asked a question but generally did not approach them when they came to the home.

We saw some people had food and fluid charts which recorded how much they had eaten and how fluid they had drunk every twenty four hours. The charts we looked at had a recommendation people should drink 2,000 millilitres (ml). The fluid charts stated staff should document in people's record if they did not drink 2,000 ml. The fluid charts we looked at recorded people had drunk less than 2,000 ml and this had not been noted in their record. A senior member of staff told us people's optimal fluid intake was calculated according to their height and weight and this was documented in their care record. This contradicted what the fluid charts stated. Daily progress records did not refer to fluid intake and staff we spoke with were not sure how much each person was expected to drink. The manager had taken responsibility for this and food and fluid charts were collected in and totalled by the manager of the service every two days. They said they did not document the volume of fluid taken in peoples individual care notes. We did not see how people's fluid intake was being effectively recorded. However we saw people had been offered fluids on a frequent basis throughout the day.

The manager told us people had access to other health professionals and we saw visits from other professionals such as the GP or tissue viability nurse had been recorded in people's care record. During the inspection we observed a visit by dietetic staff to discuss the care of one person who used the service in relation to their dietary requirements. We saw another person had input from the physiotherapy service. However, in one of the care records we looked at we saw the recommendations made by the Speech and Language Therapist (SALT) was not recorded in the person's care record. This showed us there was a risk people's nutritional needs would not be met because the provider had not taken steps which ensured the

recommendations from the SALT had been recorded. People we spoke with told us they felt their GP was called quickly when they were not feeling very well.

Some people who used the service lived with dementia and required support to find their way around the building. We saw there were signs on the doors to the bathrooms and toilets so people knew what was behind the closed door. This enabled people to retain some of their independence because they did not have to rely on staff. We saw doors to people's rooms had been designed to replicate a front door, complete with letter box and door knocker. On each door was a frame and the manager told us the aim was to put in photographs of people or items personal to them so they would recognise the door to their bedroom. Two of the frames had been filled with photographs of the person or with some of their personal mementoes. Other frames did not contain photographs or mementoes and the manager told us there were plans in place to fill up the frames.

Good

Is the service caring?

Our findings

People we spoke with thought staff were very kind and caring. One person told us, "They [staff] are lovely and they are very patient with me." Another person told us, "I wouldn't like to be anywhere else, I get on well with staff and I like the place." Other person told us, "The staff are kind to me and I get on with them all. They know how I like things done; it's a happy place to live."
One of the visitors we spoke with told us, "The staff are very nice and [person's name] gets on well with them."

We observed staff had a good relationship with people and treated them with kindness and compassion. One person told us staff had a good understanding of their support needs. They told us, "Staff come and re-position me frequently and always remember which side I am due to go onto next."

However when people chose to stay in their bedrooms they commented they felt isolated and lonely because staff didn't have the time to sit down and spend some time with them.

One member of staff said the home was a good one and people were happy there. They told us, "We give good care." Other staff said all staff cared about people and, "When we go home we still think about people." the staff member told us, "Staff genuinely care because they bring things in for people living in the home, such as CDs and Birthday cards, the residents are nice people, different groups who get on with each other." We checked with the policy of the home to establish whether this was allowed. The nurse told us it was within the remit of the policy for the home to buy birthday cards for people and staff brought in books and CD's they no longer wanted or used.

We asked the two care staff we spoke with to tell us about the support needs of people who used the service. They were able to tell us about people's care needs, what they liked to do during the day and details about their preferences. The way staff spoke about people indicated care, warmth and understanding. During the inspection one person was distressed and we saw staff sit with them and talk to them to reduce their distress.

One member of staff told us they had received an introduction to equality and diversity training. Staff talked about the ways they encouraged people's independence in everyday activities and choices. Staff told us how they would maintain people's dignity, for example they told us they ensured people had privacy during any personal care. We saw staff knelt down to the person's eye level when they asked them any personal questions. This ensured they were not overheard.

As we walked around the home we looked into the bedrooms of four people who used the service. We saw the bedrooms had been personalised with pictures on the wall and photographs of their family around the room. Personalising bedrooms can help care staff get to know the person and helps to create a sense of familiarity and make a person feel more comfortable.

Care staff we spoke with understood the need to maintain information confidentially. For example, not to

talk about people living at the home with anyone who did not need to know. They were aware of how to store records securely. One staff member said they always put people's files away and closed the cupboard; however the cupboard did not lock. We saw the records were kept in a cupboard with a lock on it. The cupboard was in an area easily accessible to people who used the service and any visitors to the home. During the inspection the cupboard was not always locked. This meant there was a risk care records which contained personal information were not being kept in a way that maintained confidentiality.

This example is a breach of Regulation 10 (2) (a)of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

One member of staff told us that End of Life care was provided with support from specialist nurses via the patient's GP. We saw end of life plans were in place so staff were aware of how people wanted to be treated when they were at their end of life. This showed us the service had taken steps to respect people's dignity at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

Not all the people we spoke with were aware of their care. Only one person we spoke with was aware of their care record. They told us staff would sit down with them and talk to them about their support needs.

We looked at four people's care records. We saw people had an assessment prior to moving into the home. Care plans followed on from the risk assessments carried out. The records focussed on the support needs of each person and included care plans for; mobility, choking, communication, social activities and skin integrity. Personal histories were in place but were not always completed, for example people's likes and dislikes were not always recorded in people's life history. In one of the care records, we saw a document entitled 'map of life' which had been completed. This focussed on things that were important to people such as relationships. In the same record there was a document entitled 'Life Story Book' which had not been completed. This would have given care staff an understanding of the background of people who used the service.

We saw Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms were in two of the care records we looked at. We could not see any evidence the DNACPR decision had been discussed with people who used the service or their relatives. We could not see any evidence mental capacity assessments had been carried out in relation to the DNACPR decision. We discussed this issue and recording end of life wishes with the manager. They acknowledged it was a difficult conversation to have with people but understood it was important to establish people's wishes and for staff to act in accordance with these wishes. The manager told us advance care planning was in the action plan for the home and would address the gap. The action plan we looked at did state all people who used the service were to have advanced care planning.

We asked staff members what they thought about the care records. Two staff members told us they did not usually read them because the staff handover sheets contained all the information they needed to support people effectively.

We looked at the handover sheet and saw it was a very detailed document which outlined people's medical history, their risk of falls, the kind of diet they were on and what their mobility support needs were. Each staff member was given a copy of the handover sheet for them to refer to throughout their shift. This meant people were being supported by staff who had a good understanding of people's current support needs. The nurse we spoke with described the handover process as, "Thorough."

Although the majority of care records were person centred and reviewed each month this was not consistent. For example one person had been assessed as being at risk of developing a pressure ulcer and a care plan was written on 1 April 2015 to enable staff to minimise the risk of an ulcer developing. The risk assessment had been reviewed monthly and in spite of the person developing a pressure ulcer the care plan had not been re-written. From the care record we could not see when the ulcer was noted and the only references to the ulcer was found in the updates. This information was vague for example one entry stated, 'prescribed creams and frequent pressure relief given.' There was no evidence the ulcer had been measured and assessed to provide staff with appropriate guidance, determine progress and assess the effectiveness of

the treatment.

People we spoke with told us 'residents meetings' were held but could not tell us how often. We looked at the schedule for 'residents meetings' and saw they had taken place three times during 2015. Relatives we spoke with told us they were invited to attend relatives meetings and although they could not attend them felt it was important the home involved them. This showed the service organised meetings where people and their relatives gave their opinions on the home and how it was run.
We looked at the complaints file and saw any complaints had been addressed in line with the policy of the service. The manager told us not many complaints had been received and so they were not able to establish whether any patterns had emerged.

Relatives we spoke with told us the staff at the home kept them up to date with the health and well-being of their relative. They told us staff let them know if their relative required any medical interventions in a timely manner. The external professional we spoke with had observed how staff reacted when a person in the home fell, they told us, "Reaction from staff was spot on."

The service employed two activity co-ordinators and we saw a list of activities on offer included reminiscing, music quiz. On the day of inspection, a music quiz took place and people enjoyed taking part. People we spoke with told us they had a choice as to whether they took part in the activities. One person told us, "I like to sit and listen to the music and join in activities when I want to."

Requires Improvement

Is the service well-led?

Our findings

The new manager had been in post since the beginning of December 2015 and the previous registered manager had left in November 2015. There had not been a large gap between managers and the new manager felt this change had not had a great impact on the service.

People who used the service told us they knew who the new manager was. One person we spoke with told us, "I like her, she's a good manager." Relatives and visitors we spoke with felt the new manager was approachable and listened to any concerns they had.

The external professional we spoke with told us there had been a lot of changes within the home recently and felt the new manager was aware of what further changes were required. The staff we spoke with told us the manager was good, approachable and visible around the home. Staff felt they had a good understanding of what was expected of them and were aware of the vision of the home.

Although the manager was new in post, they had been working at the home in a different capacity so had a good understanding of the history of the home and what changes needed to be made. They showed us the action plan for the home. The action plan was detailed with target dates but none of the target dates had been recorded as being met. However we saw some of the action points had been met such as health and safety risk assessments. It was clear from talking with the manager they were passionate about the home and people who lived and worked there. They felt it was important for staff to receive praise when they have done a good job and to be challenged when they have not performed well.

We asked the manager to tell us what they felt their challenges were. They told us recruiting staff, especially nurses, was a challenge. They acknowledged there were staffing issues and realised the needs of people who used the service had changed. The needs of people living with dementia were just as great as people with nursing needs and the allocation of staff had recently been changed from tasks centred to more person centred care. The manager felt staff were on board with this new approach.

The manager told us they were considering asking staff to become champions for specific issues in the home, for example dignity champions. They felt staff were skilled and knowledgeable and worked well together as a team. They told us, "There are some issues but we are working through these."

We saw different staff meetings were held regularly and this gave staff the opportunity to give their own feedback about the service. Meetings were held for the care staff, managers, domestic and kitchen staff. This meant the manager ensured communication routes were available for staff.

The home had a system in place for maintenance and we saw regular audits had been carried out. The home employed a maintenance person whose role was to carry out all the health and safety checks within the home. We saw examples of recent checks on wheelchairs, health and safety checks and fire risk assessments. The manager told us they walked around the building each morning and then throughout the day to ensure staff were meeting the needs of people who used the service. We saw medicine audits were in

place as were audits of accidents and incidents. Accidents and incidents had been recorded in line with the policy of the service. We saw the records had been monitored monthly and audited annually. The manager told us they had already noticed the number of falls was greater at night and would be investigating this with the aim to put in place a system to reduce the number of falls during the night.

We saw policies and procedures in place to support staff in their role. The policies had been updated and reviewed. Reviewing policies enables registered providers to determine if a policy is still effective and relevant or if changes are required to ensure the policy is reflective of current legislation and good practice.

There was an effective complaints system available. We saw comments and complaints people made had been responded to appropriately.

We saw a statement of purpose pinned to a notice board in the reception area. This meant people who visited would be able to read about the vision and purpose of the home when they were making a decision about moving into the home.

Throughout the inspection we had noted a number of breaches including; recording of information, the lack of MCA assessments and consent not being sought for the use of bed rails. This demonstrated the home did not always have effective quality assurance and governance systems in place to drive continuous improvement.

This lack of oversight demonstrates a breach of Regulation 17 (2) (c) of the Health and Social Care Act (regulated activities) Regulations 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect Care records were not being kept in a secure cupboard and there was a risk people could have access to sensitive information. Regulation 10 (2) (a) of the Health and Social Care Act (regulated activities) Regulations 2014. Dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care was nto always being sought in line with the MCA. This was a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. need for consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People's capacity to make a decision to stay in the home or have bed rails in place was not being assessed. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Safeguarding people from unlawful restraint.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The manager did not have an oversight into the issues raised as part of the inspection. they had not identified gaps in recording and care records not being kept securely. Regulation 17 (2) (c) (d) Health and Social Care Act 2008 (regulated activities) Regulations 2014. Good Governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff available to meet people's needs in a timely manner. Regulation 18 (1) of the Health and Social Care Act 2008 (regulated activities) Regulation 2014. Staffing