Care Quality Commission

Dolphin Property Company Limited

Cedar Lodge

Inspection report

South Road, Norton, TS20 2TB
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 29 June 2015 and 02 July 2015. The first day was unannounced which meant the staff and provider did not know we would be visiting. The provider knew we would be returning for the second day of inspection.

Cedar Lodge is a two storey purpose built building which was able to provide accommodation for up to 54 people who need help and support. There was a lift to assist people to get to the upper floor. At the time of our inspection there were 27 people living at the service.

Our records showed that there was a registered manager at Cedar Court, but they had recently left the service. At the time of our inspection, the deputy manager was acting as the service manager and during our inspection had accepted the position of manager at the service and would be applying for their registered manager status in due course. 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.

We previously inspected Cedar Court in July 2014. At that inspection we found the service was not meeting all the standards which we inspected. We found that instructions from health professionals had not always been followed and care records, particularly fluid records had not always been completed appropriately. Mental

Summary of findings

capacity assessments were not in place for those people who needed them. There were gaps in medicine administration records and we found that some medicines had not been available

Safeguarding alerts were appropriately recorded and showed that staff had taken the action needed. Staff we spoke with were able to provide good examples about things that could present as abuse and the action they would need to take. Safeguarding training was up to date and CQC had been notified of all safeguarding alerts. Risk assessments for the day to day running of the service and more specific risk assessments individual to people were in place and regularly reviewed.

At the time of this inspection the service was under its maximum occupancy levels but still retained its normal staffing levels. Everyone we spoke with [people, relatives and staff] all confirmed that there were enough staff on duty.

Medication was managed safely and people received their prescribed medication on time. Staff had information about how to support people with their medicines. However topical cream records did not always provide details about when and where to apply creams. From the records we could not be sure if people received their topical creams regularly.

Not all certificates for the running of the service and equipment were up to date. Cupboard doors which should have been locked were left open and a fire exit had been blocked. Infection control and prevention procedures were not always carried out appropriately.

Staff had received up to date training and regularly participated in supervision however staff appraisals were not up to date though had been planned for the rest of the year.

People told us they received enough to eat and drink. People were supported at mealtimes and were encouraged to have drinks and snacks throughout the day. Staff responded quickly when people lost weight and acted appropriately to ensure appropriate health professionals were involved in their care.

People spoke positively about the care and support they received from staff. We could see that people could get up when they wanted to and could have meals later if they wished. We observed staff respecting people's privacy and dignity.

Care plans were in place but were not consistently reviewed. There was little evidence of people's involvement in decisions which affected them. We found gaps in people's care records and in records relating to the day to day running of the home.

Staff had acted appropriately to deal with complaints. There was no information about advocacy on display at the service.

Staff spoke positively about the leadership in the service and about themselves as a team. We could see that staff were happy working at the service.

Audits had been carried out and action plans had been put in place, however they had not always been addressed.

We found breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the premises and equipment and records. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Health and safety checks, certificates and equipment were not always up to date. Door which should have been locked were accessible during inspection. Risk assessments for the health and safety of the building had been carried out.

Safeguarding alerts had been logged and dealt with appropriately. Risk assessments for people who needed them had been carried out.

Procedures were in place for the safe management of people's medicines and we found that medicines were managed safely. Topical cream records did not detail when and where to apply creams.

Infection control and prevention procedures had not always been followed correctly.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff supervision and training had been carried out regularly. Appraisals were not up to date for all staff but had been planned.

Mental capacity assessments had been carried out for the people who needed them, however the people involved in this decision making process was not always clear. Staff training in this area was up to date, but not all staff were clear about their responsibilities and the procedures which they needed to follow.

People were supported with their dietary intake. Staff took appropriate action when people lost weight. Health professionals were regularly involved in people's care.

Is the service caring?

Good

The service was caring.

Staff understood the importance of maintaining people's dignity when providing care and support to them. We observed staff knocking on people's doors and seeking permission before care was given.

Care was given when people wanted it. People could get up when they wanted to. People had choice about how to spend their day.

There was no information about advocacy on display at the service. We did not know if people had access to independent support when they needed it.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were gaps in the records which we looked at. Care plan reviews were not always carried out regularly. Records did not always show people's involvement in decisions which affected them.

There was a lack of activities available at the service. We found that the activities co-ordinator was not always able to dedicate their time to activities when staffing levels were low.

A clear complaints procedure was in place at the service. Complaints had been recorded and investigated appropriately. All staff felt confident about the action they needed to take when dealing with a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits were regularly carried out and action plans put in place. Action plans were not clear whether actions had been addressed and the in some cases, the same actions had been in place for some months.

People, their relatives and staff had been invited to participate in meetings and had been kept informed about changes which affected them. Meetings had been carried out at different times to increase attendance.

There was good leadership at the service and staff worked together as a team to ensure the smooth running of the home on a day to day basis.

Cedar Lodge

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.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

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.

The inspection was carried out on 29 June and 02 July 2015. The first day of the inspection was unannounced; this meant the service did not know we were coming. The second day of the inspection was announced. The inspection team consisted of two inspectors and a pharmacist. During our inspection we spoke with five people who used the service, two relatives and one visitor. We also spoke with the operations manager, acting manager, chef, a nurse, five care staff, the activities coordinator, the maintenance man and a member of domestic staff.

We observed care and support in communal areas of the service and spoke with people who used the service in private. Not everyone we spoke to could communicate with us. We carried out a short observational framework for inspection (SOFI). This is a way of observing and reporting the quality of care experience by people who cannot communicate with us. We also looked at four care records, staff records and reviewed records which related to the running of the service and the quality of the service.

Is the service safe?

Our findings

External maintenance checks of fire fighting equipment were up to date. Fire checks [by the service], had been carried out by the maintenance person. Records showed where action had been taken. These fire record book had not been reviewed every month by the management team. This meant that the service was not monitoring the fire safety of the service effectively. Fire drills had been carried out regularly with both day and night staff. Response times had not been recorded, this meant we could not see if fire drills had been effective or whether further action was needed. A recent fire incident at the service had been fully documented.

On the second day of our inspection we found that the shower room and staff room doors [on opposite sides of the corridor] had been wedged open together [door handles interlocked] which meant that the fire door at the end of the corridor was blocked and could not be accessed quickly in an emergency. We closed both of these doors straight away to unblock the fire exit and told the acting manager straight away. On both days of our inspection we could see that equipment was being repaired in one of the empty bedrooms, [equipment which had been taken apart had been left on the floor]. This was a trip hazard to people who used the service and staff. We spoke with the acting manager and asked them to address this immediately. During our inspection, we found doors which should have been locked were accessible to people, this included the sluice and cleaning cupboard which contained products deemed hazardous to health.

Gas and electrical safety, portable appliance testing (PAT) and hoist certificates were up to date, however we found some certificates had expired. This meant we could not be sure if some of the premises and all equipment were safe for use. The nurse call system certificate expired in March 2015. A chlorination certification expired in January 2015. The lift had not been serviced since February 2015 [servicing was due in May 2015] and the servicing certificate for the extractor fan in the Kitchen expired in May 2015. The chair scale calibration certificate expired in May 2015. We spoke with the acting manager and asked them to take action straight away. Water temperatures had been carried out regularly and had been recorded appropriately.

Records showed that bi-annual checks of the water by an external contractor was required each year. We found that these checks had not been carried out this year [one check should have been carried out].

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 premises and equipment. Not all equipment needed for people for the running of the service were regularly serviced. Health and safety checks were not up to date.

At the last inspection we found that the registered person had not protected people against the risk of care and welfare because some medicines had not been available and there were gaps in the medicine records. This was in breach of regulation [12 (f) and (g)] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that action had been taken to ensure the service was meeting the regulation.

At this inspection, people told us they received all their prescribed medication on time and when they needed it. We observed medication being administered to people safely. Medication kept at the service was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators which stored items of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

Staff had signed people's medicine records when they had given people their medicines. Records had been completed fully, indicating that people had received their medicines as prescribed for them. Staff had recorded the reason if a person had not taken their medicine. Since our last inspection staff had introduced a system to record when they had applied creams and ointments. This included a body map which described to staff where these preparations should be applied, however we not all records which we looked at provided information about the frequency of which the creams should be applied and where on the body the creams needed to be applied. From the gaps in the records we could not be sure if topical creams were being applied regularly [as prescribed by people's general practitioner]. In one person's topical cream records we found that there were only four days in June in which their prescribed topical cream had been

Is the service safe?

recorded as being applied. At our last inspection [July 2014] we highlighted gaps in the medicine records. Staff told us they were still working on improving these records and ensuring they were always completed.

We looked at the guidance information kept about medicines to be administered 'when required'. Arrangements for recording this information was in place for most people however we found this was not kept up to date and information was missing for some medicines.

We recommend that the service consider the current guidance on managing medicines that need to be administered 'when required' and take action to update their practice accordingly.

Safeguarding referrals had been made when needed and were logged in detail and shared with the local authority on a monthly basis. This meant that the service could monitor on-going safeguarding alerts and take action to minimise the possibility of similar events happening again. Staff were able to give good examples of the types of abuse they might see in the service and could describe in detail the action they would take if needed; this included who to contact to make referrals to or who to contact for advice and support if needed. A whistleblowing policy and procedure was in place at the service and all staff we spoke to were aware of this. All staff told us they would whistle blow [tell someone] if they needed to. There was detailed information on display about safeguarding in the staff room. This meant staff had access to the information they needed and staff training in safeguarding was up to date. People's human rights were protected

The five people we spoke with [and who were able to] confirmed that they felt safe living at the service. One person who used the service told us, "I feel safe living here." Their relative confirmed that they felt that their relative was safe living at the service. Our observations showed that staff carried out appropriate moving and handling techniques when supporting people.

We looked at the recruitment files of the last six members of staff. Robust documentation was in place to show that people had completed an application form and had attended for an interview. Two referees had been contacted and provided references for each staff member. Staff had a Disclosure and Barring Services (DBS) check prior to working at the service. This is a check which enables employers to check the criminal records of potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children.

The acting manager told us that the service was under-occupancy at the time of our inspection but normal staffing levels remained. Records from a recent compliance visit [April 2015] from the registered provided showed that the service was over staffed. Staff told us they had time to spend with people; we observed this to be the case during our inspection. We could see that agency staff were used regularly at the time of our inspection to cover nurse duties during night shift whilst the position is being advertised. The service had its own internal bank staff who could cover shifts at short notice.

A fire risk folder was located in the administration office and in both clinical offices. Information was colour coded according to risk. This meant that the service had quick access to information which detailed the support people may need in an emergency. All staff told us they felt confident dealing with emergency situations. We could see that a nurse qualified in first aid was available on every shift.

Security procedures were in place at the service. We were required to show identification before entering the service and had to sign the visitor's book. This meant that the service was following appropriate procedures to keep people who used the service and staff safe. We found that all staff work identification badges. There were photographs on display at the service to show which staff were on duty, including their name and role. This meant that we could approach the most appropriate staff members when we needed to speak with them.

All accidents and incidents in the service were logged appropriately and analysis of these was carried out to monitor any trends and patterns [types of accidents and times of accidents]. Risk assessments related to the day to day running of the environment [trips, slips and falls, legionella, electrics, chemicals and falls] were in place and had been reviewed in February 2015. General risk assessments [such as moving and handling, infections, first aid and medicines] were in place. More specific risk assessments were available in the care records of people who used the service and were reviewed regularly. These included things such as nutrition, falls, and manual handling, constipation, and pressure sores were in place.

Is the service safe?

Dedicated domestic staff were on duty and there was an infection control champion. We could see that the service was clean and tidy. We found that each room at the service [where appropriate] did not consistently contain soap or a bin or bin liner for used paper hand towels. We found that the microwave in the staff room required cleaning. Some of the hand gels on display around the service were empty. We spoke to the acting manager about this on the first day of our inspection and asked them to take action. At the end of our inspection on the second day we found that action had not been taken. Personal protective equipment [gloves and aprons] were available and on display.

We recommend action is taken to ensure infection control and prevention procedures are kept up to date.

A number of walking frames had been stored in a clinical area which people had access to. We found a store cupboard; the sluice and a cleaning cupboard were unlocked despite the signage on them requiring them to be locked. This meant that people could have been at risk of harm. We spoke with the acting manager about this and immediate action was taken. On the second day of our inspection we found that these doors were locked and equipment had been moved.

Is the service effective?

Our findings

The acting manager told us all staff received monthly supervision. We looked at ten staff supervision records from January 2015 to June 2015; we could see that staff had received between three and five supervision sessions in the last six months. Supervision is a formal meeting between two people and aims to support the staff member to develop and carry out their role to a high standard. One staff member told us, "Regular supervision is effective." An appraisal is a formal process between two people to look at staff development over the coming year. We found that all staff had not had an appraisal in 2014. We could see that the acting manager had put an appraisal planner in place to ensure that all [57] staff received their appraisal before the end of the year. At the time of our inspection 12 staff had received an appraisal at the time of our inspection.

We recommend timescales for completing appraisals are reviewed.

We looked at the training records. We could see that the majority of staff had received a range of training courses such as fire safety, moving and handling, infection control, safeguarding, the Mental Capacity Act and Deprivation of Liberties Safeguards. The training records showed that only nursing staff had been trained in first aid. The acting manager told us that they had discussed plans to provide training to care staff [in first aid] with senior management and this was planned for later this year. This is good practice to ensure that all staff are trained and confident in dealing with situations where medical assistance is required. We could see that some staff had also received training in medicines, pressure sores and wound care, depression, incontinence, nutrition, end of life care, using syringe drivers and catheter care. One staff member told us, "I like training. The more you know, the better you are to your job." Another staff member told us, "The training is good. I enjoy face to face training."

We looked at the induction records of the last six staff. We could see that all new staff shadowed more experience staff during their induction programme. This meant that new staff had the opportunity to get to know people who used the service and the staff team before working independently. During the induction programme staff also became up to date with health and safety procedures in the service and a looked a range of relevant policies.

Essential training such as fire safety and moving and handling was also completed. All new staff undertook a knowledge check by more senior staff to check they were ready to work unsupervised.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the rights of people who may need support to make decisions are protected. Training records showed staff had received recent training in the principles of MCA. Not all staff had a good understanding of these principles, their responsibilities and the procedures which they needed to follow. Not all staff understood the potential restrictions which could be placed upon people.

Care plans contained assessments of the person's capacity when they were unable to make a decision. Care plans detailed the efforts which had been made to establish the least restrictive option for people which had been followed and the ways in which staff sought to communicate choices to people. Not all records of people who used the service who had been assessed as being unable to make complex decisions detailed meetings with the person's family, external health and social work professionals. Records did show when staff were involved in these decisions. Lack of detail about people's relatives, advocate or an independent mental capacity advisor (IMCA) involvement meant that we could not always be sure if any decisions made on the person's behalf were done so after consideration of what would be in their best interests.

The Care Quality Commission is required by law to monitor and use the Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The acting service manager was aware of their responsibilities in relation to DoLS and was up to date with recent changes in legislation. We saw the service acted within the code of practice for MCA and DoL's in making sure that the human rights of people who may lack mental capacity to take particular decisions were protected. The acting service manager told us they had been working with relevant authorities to apply for DoLS for people who lacked capacity to ensure they received the care and treatment they needed and there was no less restrictive way of achieving this. At the time of our inspection DoLS had been approved for 14 people who used the service. A DoL's checklist was in place at the service. This showed which

Is the service effective?

people who used the service had a DoL's in place, when the DoL's was granted and when it was due to expire. This meant staff could take appropriate action to determine whether a new application was needed.

We recommend that mental capacity assessments always show the people who have been involved in this decision making process.

Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) certificate in place. The certificate showed who had been involved in this decision making process and a review date was in place. Most staff we spoke with showed a good understanding of what this certificate meant for them and the person they related to. Some staff did not know the circumstances in which a person could be considered for a DNAR certificate. Staff knew which people they cared for had a certificate in place; this meant that people's wishes could be respected in these circumstances.

People had regular access to health professionals. People we spoke with, our observations and records confirmed this to be the case. Care records showed that referrals for things such as physiotherapy and speech and language therapy had been carried out for people who needed them. People we spoke with during our inspection confirmed that they could see the health professionals they needed when they wanted to.

Menus were on display [in written and pictorial format] in each of the dining areas at the service. The service had a nutritional champion in place. Detailed information about people's dietary preferences and requirements were available which meant that staff could cater to people's individual needs. We could see that people always had a choice of meals available to them; staff told us that where people did not want the food which was available on the menu, an alternative choice would be offered. People we spoke with confirmed this to be the case. Regular snacks and drinks were available during our inspection. One person told us, "I get enough to eat and drink." Our inspection was carried out on a particularly hot day; staff made sure that drinks were readily available throughout the day and people were prompted to increase their hydration. The activities coordinator arranged ice creams for people during the afternoon. All staff knew about the signs of dehydration and the action they needed to take if they suspected people were becoming dehydrated.

Staff were available during mealtimes to support people with their meals. Support was individual to people and was carried out in a dignified way. Positive interactions were observed from all staff during mealtimes, people were given the time they needed and were not rushed. All staff were very knowledgeable about the different ways in which they could support people to increase their nutritional intake if needed, for example, increasing the calorific value of food using cream or ice-cream or providing foods with a softer texture. One staff member we spoke with provided detailed information about how one person's health condition impacted upon their dietary intake. The staff member told us how they supported the person to eat when their appetite decreased. We could see that people's weights were monitored regularly and referrals to dietician had been made when appropriate. Staff followed the guidance given by the dietician.

People who used the service had information called 'All about me' which was used when people needed hospital treatment in an emergency. These records included information about the person, their medicines, any advanced decisions and DNAR certificates which were in place. This meant that hospital staff would be able to provide the most appropriate treatment to people quickly.

Cedar Court was a purpose built building. Each floor had a lounge, quiet area and dining room. Bedrooms were spacious and people who used the service had access to the garden and patio area. Each area of the service was maintained to a good standard. The operations manager discussed planned improvements to the service which included updating the kitchen and people's bedrooms. The acting manager told us that the garden was not accessible for people with dementia and plans were in place to make this more accessible. We could see that plans were place to continue with the high standard of maintenance and decoration in the service.

Is the service caring?

Our findings

From our conversations with people and their relatives and from our observations of staff, we could see that staff knew the people whom they were caring for well. One staff member told us, "The environment in the service is lovely. The service users are lovely. I like to talk to people about their life histories." Staff told us about how they supported people in a way in which was individual to each person. The background knowledge staff had about people [life histories and experiences] meant that they could provide more detailed care to them and could use this information to carry out reminiscence activities with people. One person told us, "I feel safe living here. I have no concerns. People are so friendly. Staff know my needs." Another person told us, "I am well looked after."

The relatives we spoke with told us they were happy with the care provided to their family members. One relative told us, "I have no concerns about my relatives care. The staff know them well. They get enough to eat and drink and staff are aware of their likes and dislikes." All people we spoke with confirmed that they were happy with the care provided to them. One person told us, "It's lovely here, I'm very happy" and "The staff are all so nice and very polite, they are always popping their heads round my door to see if I'm ok." Another person told us, "I can't fault the staff." All staff we spoke with told us they enjoyed working in the service. One staff member told us, "I love it here. I came for work experience and stayed." Other staff told us, "I'm here for our residents." And "There is a good team work here. We have fantastic carers." And "We go above and beyond with our care. It shows [in the relationships] with our residents and families. It's important to come with a good attitude."

We attended the service early morning during both days of our inspection. We found that some people were still asleep and were able to get up when they wanted. One staff member told us, "Mornings are laid back. People get up when they want to." One person told us, "I'm a midnight owl and there's no problem if I want to stay up late, I have friends in other nursing services who have to go to bed at ten o'clock and I wouldn't like that at all." We saw that breakfast was provided to people at different times throughout the morning when they wanted it. A dignity champion was in place at the service. We saw staff knocking on people's doors before entering their rooms. People were asked for their permission before care and support was given and people were given the time they needed when this care and support was given.

All staff we spoke with were confident about managing behaviours which could challenge. We could see that staff worked together to support people [and each other] to make sure that the best care and support was given to people. We observed all staff demonstrating empathy to people and they encouraged people to be independent when appropriate. One staff member told us, "The staff are excellent. They are good with people and will just sit with people if that's what they [people] want." Staff told us about how they provided reassurance to people when they needed it. They gave examples of distraction techniques which could also be used. We also saw staff spending time with people, simply chatting about the things which were important to them. We heard lots of laughter, singing and dancing throughout our visit to the service.

The atmosphere at the service appeared relaxed. People were not rushed and staff did not appear to be rushing around. Care and support was provided when people wanted it. People who used the service were able to spend their time how they wanted to.

There was no information on display in the service about advocacy. We spoke with the acting manager and asked them to address this straight away. Advocacy is a means of accessing independent advice and support. An advocacy policy was available in the manager's office.

Is the service responsive?

Our findings

We looked at six induction records and found that there were two induction records for the same person. We found that the dates of completed modules on both these forms did not always have the same date on them. The manual handling overview section was required to be signed off within two weeks of the staff member starting work; however the records showed that the staff member started work on 11 December 2014 and this was not signed off until 25 February 2015. Two induction forms had been signed but not dated; this meant we did not know if the key areas of the induction programme had been completed within the allocated timeframe. One of the key areas of induction involved shadowing staff for a week; three induction records showed that this had been signed off on the first and second day of the week allocated for this shadowing. This meant that we did not know if staff had completed a full week of shadowing.

We looked at the care records of four people and identified gaps within these records. Oral healthcare assessments for all four people had not been completed since January 2013. We spoke to the acting manager and they told us that these assessments were no longer completed and would take action to remove these records for people's care plans. We found a continence assessment for one person had been carried out in October 2014 and had not been completed since.

A 'daily statement' record was in place for staff to complete which showed whether people had been provided with personal care, food and hydration and activities. We looked at 23 records for one person for the month of June 2015. We found gaps in activities; individual needs for person care, fluids and totals, the name of the staff member responsible each day and their signature. Each person who used the service had a minimum fluid intake they needed to achieve each day. In one person's record we saw that this had been calculated at 3210 millilitres per day. We spoke to staff and found that this had been wrongly calculated and should have been 2310 millilitres per day. In all four records we found gaps relating to dietary consumption. We found that the amount of fluids recorded [as being consumed by people] was often less than the recommended daily consumption needed on the record. There was no evidence of any action being taken when fluid intake was lower than this recommended amount. This was highlighted at our last inspection of the service in July 2014.

Care plan reviews were carried out monthly. We found care plan reviews were inconsistent. For example, for one person we found a care plan for communication had been reviewed each month, but a care plan for breathing had not. We found care plan reviews for people were repetitive and not person centred with reviews stating "remains the same." Reviews did not reflect the care plans of people they related to, for example, the breathing care plan did not make any comment about the person's breathing of use or their inhalers.

Care records also contained 'six monthly reviews' but we found these had not been carried out since 2013. This meant that we did not know if these were relevant to the service anymore. We spoke with the acting manager and they told us they were aware that these six monthly reviews had not been carried out but were still active to the service.

A psychological assessment was carried out each month and looked at different aspects of the person [incontinence, confusion, appearance, supervision, activities, social contact and communication]. We found that the monthly reviews of this assessment contained limited information and did not reflect each aspect of the person identified in the documentation. We found many entries in the evaluation stated "no confusion present" which did not accurately reflect the assessment tool.

Care plan reviews did not show if people and their relatives were involved in the care planning and review process. The reviews had not always been signed by people to show that they agreed with the plan which had been put in place. This meant that we did not know if people were involved in making decisions about the care and support which they needed. Reviews contained limited information, one review stated "family are aware" but did not state if information from the review had been shared with relatives. Records did not record any details of the discussions which took place. This meant we could not see if the review had been effective

A Mental Capacity Assessment carried out for one person showed the involvement of staff. Records did not show any involvement from family, advocate or independent mental

Is the service responsive?

capacity advisor. This is important to ensure that the person involved in the assessment has had appropriate access to help and support about decisions which may affect them.

A consent form to take photographs and to share information had not been signed by the people they related to. We could see that photograph's of people who used the service had been taken. This meant that we did not know if the person had consented to this.

This meant there was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation [17 (2) (c) and (d)] because records were not always accurate and up to date. There were gaps throughout the records which we looked at and records did not always contain the information they required. Records did not always show people's involvement.

Staff had read people's care plans and signed documentation to show they understood the information recorded about people's needs and wishes. This meant staff had the guidance they needed to provide personalised care and support to people. We found that care plans provided detailed information about the care and support people needed. A Meticillin-Resistant Staphylococcus Aureus (MRSA) pathway had been put in place for one person which included factsheets about MRSA; this is good practice to increase the knowledge of staff providing this specific type of support. We found that this information was very detailed and clearly documented the action staff had taken to support the person. Treatment protocols were clear about the action staff needed to follow and care plans and risk assessments had been updated. Wound care records were up to date. We spoke to the nurse on duty and found they were very knowledgeable about the procedures which they needed to follow to care and support people with MRSA and to help to stop the risk of infection to other people in the service.

Records in the "assistance needed" section of people's care records were very detailed and provided personalised information. This meant that staff could read this information and be able to provide support appropriate to the person. Pre-admission information was detailed and the assessment had been fully completed. Life histories had been fully completed and provided a lot of detail about the person's life which meant staff could use the information to reminisce or to initiate conversations. Daily records had been completed each day.

At our last inspection [July 2014] we highlighted that there were a lack of activities taking place in the service. At this inspection we found that there was still a lack of activities taking place. One person we spoke to, told us, "I don't know about any activities taking place." There were activity timetables on display at the service; however on both days of our inspection we did not see any planned activities taking place. We spoke with the activities co-ordinator told us that activities often changed due to the demands in the service or because people chose to do something different. The acting manager told us that the activities co-ordinator was [at times] asked to carry out other duties which could include care and domestic tasks during sickness. This meant that during these times activities were not provided in the service. One staff member told us, "We need more staff dedicated to carrying out activities." Another staff member told us, "We only have one activities co-ordinator to cover both floors in the service. They could be a lot more activities, we would do it if we had time." Staff told us that people particularly enjoyed craft based activities; some staff felt that some activities equipment needed updating.

Activities records were very limited and did not reflect the activities which had taken place at the service. We could see that people participated in activities and went out into the community to local shops, parks and beaches using the minibus which the service owned; the activities coordinator told us, "During the last two months we have been out every Monday. Last week we took people out the local armed forces event." Some people accessed the community on their own. We saw that staff appropriate monitoring was in place to protect these people. This meant that staff were supporting people to remain independent and have access to the hobbies and activities which were meaningful to them.

The acting manager showed us a newly developed activities folder which detailed the changes which the registered provider had planned to put in place to improve the quality of activities in the service. The activities guide provided guidance about activities and the types of activities which could be carried out in the service. At the time of our inspection, this had not been implemented in the service.

Complaints had been reported and investigated in line with the registered provider's policy. This policy clearly outlined

Is the service responsive?

the action staff needed to take to address complaints. We could see the service had taken appropriate action to deal with complaints. One person we spoke to told us, “If I had a complaint, I’d tell the staff.”

Is the service well-led?

Our findings

Accidents and incidents in the service were regularly analysed to highlight any patterns or trends which could inform preventative measures which could be taken to reduce the risks to people and staff. Audits were carried out each month.We found a range of audits which included nutrition, pressure sores, infection control, care plans, health and safety and catering. We found care plan audits were not clear about the number of records looked at during each audit. The registered provider's own internal scoring system was used and a rating allocated. This meant we could see what areas had been identified as requiring action.

At the time of our inspection, records of the registered provider's visit to the service were only available for April 2015 however the service's rolling action plan was available. Some areas in our report [training and consent forms] were highlighted as needing action. We found that gaps in records had not been picked up in their visit. We also found that there were some areas of the report which did not reflect our findings, for example, the report stated that food and fluid charts had been completed for all people using the service including fluid measurements [as stated earlier in the responsive section of our report there were gaps in the recording of this information].The action plan stated what actions were required and the person responsible for completing the particular task. There was a section for 'date task complete / rectified or on-going' which wasn't always clear if the action had been completed. We found that none of the actions on the action plan had been signed off as completed. This rolling action plan had been in place since February 2015.This meant that the same actions had been identified as needing to be addressed over the last couple of months. The regional manager told us about their in-house compliance team who would be visiting the service on a monthly basis to support the manager of the service. The regional manager told us, "Our own compliance team will be visiting the service each month and will look at action plans and how these are put into practice."

Regular staff meetings had taken place over the last year. Meetings were carried out at different times to accommodate the needs of staff. We could see that staff were kept up to date about changes in the business, planned improvements, training and staffing. One staff member told us, "We are kept well informed about changes." Two meetings for people who used the service and their relatives had taken place over the last seven months. A monthly newsletter was produced each month which informed on upcoming events, birthdays, employee of the month and a personal profile about them. This meant that the registered provider took appropriate action to make sure that people who used the service, their relatives and staff were kept up to date about changes which affected them.

At the time of our inspection, the service was carrying out a survey to explore where people wanted to go out in the local community. We spoke with the acting manager and they told us that no surveys about the quality of the service had been carried out with people, their relatives or staff over the last year.

The service had a registered manager in place however they recently left [June 2015] their post to work at another service with the registered provider. The acting manager was promoted to manager during our inspection; they had worked in the service for many years and knew the people they cared for and staff well. The statement of purpose for the service had been updated to reflect these changes.

We could see a united team was in place at the service. We observed staff working together in running the day to day aspects of the service and providing to support people. One staff member told us, "All the staff are helpful and close which makes the atmosphere good. There are no cliques anymore. We all work together. The place is good. If I wasn't happy here, I would have moved on." Staff spoke positively about the leadership in the service, one staff member told us, "I feel listened to and supported. They [acting manager] has time for you. They are very approachable." Another staff member told us, "The acting manager is around during the day. They are lovely and approachable."

When we spoke with staff, some of them spoke positively about the changes which had been made in the service and how this had impacted upon their working relationships. Staff told us, "Things have really improved during the last six months. I get everything I need to do my job. I am happy in my job," And "In the past there has been a lack of support. The current [acting] manager and the last manager, I've had lots of support from." And "Morale has hit the roof. It was low but now it's an enjoyable place to work. The acting manager told us, "The door is always open. Staff

Is the service well-led?

can air their concerns. We have regular meetings to set standards and expectations. We follow this up with supervisions and share information and ideas for improvements and good practice." Our conversations with staff reflected this; all staff we spoke with felt able to speak to the acting manager if they needed to. One staff member told us, "They [acting manager] are really good. I can't knock them. They are always approachable, even when they've gone home [and need to be contacted]. They are fantastic." Another staff member told us, This is "The best service I've worked in."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Certificates to ensure the safety of the premises and equipment were not up to date. A fire door was blocked.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were gaps in the care records and records related to the day to day running of the service.**