Ideal Carehomes (Number One) Limited

Newfield Lodge

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on the 27 May 2015. At the last inspection in September 2014 we found the provider met the regulations we looked at.

Newfield Lodge is a modern, purpose-built care home, for 64 older people and people who are living with dementia. It is close to Castleford town centre. The home has a nearby bus route, train station and some shops within close walking distance.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

People who used the service, relatives and staff raised concerns about staffing levels in the home. We saw that staffing levels were not sufficient at all times and there was a risk that people's needs would not be met and their safety compromised.

Where people did not have the capacity to consent, the provider did not always act in accordance with the legal requirements of the MCA 2005. People's consent to their care and treatment was not always recorded.

Summary of findings

People told us they felt safe and well looked after at the home. They spoke highly of the staff and said they were well trained. Health, care and support needs were assessed and met by regular contact with health professionals. People were supported by staff who treated them with kindness and were respectful of their privacy and dignity. Care records were not consistently detailed enough to guide staff on the care needs of people who used the service.

Overall, medication was managed safely and people received their medication when they needed it. People's views on food and menus in the home were positive. Some people who used the service and their relatives thought there needed to be more activity on offer in the home.

Robust recruitment procedures were in place and appropriate checks had been undertaken before staff began work. Staff said they felt well supported in their role and received the training and supervision they needed. Records we looked at showed a number of staff needed to update their mandatory training. The registered manager had a plan in place to ensure this was done and staff's practice was up to date.

Systems in place to monitor and assess the quality of service provision were not consistently effective. Quality assurance systems were inconsistently applied which could lead to risks being overlooked. We received positive feedback about the registered manager and management team in the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the number of staff employed to meet people's needs and people's consenting to their care and treatment.

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?
The service was not safe.

There were not always enough staff, suitably deployed to meet people's needs and ensure people's safety.

Overall, people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

People told us they felt safe and the staff we spoke with knew what to do if abuse or harm happened or if they witnessed it.

Requires improvement

Is the service effective?
The service was not consistently effective.

We found the service was not fully meeting the legal requirements relating to the Mental Capacity Act 2005. (MCA)

Health, care and support needs were assessed and met by regular contact with health professionals. People said they enjoyed the food in the home.

Staff said they received good training and support. However, there were a number of staff who needed to update their mandatory training.

Requires improvement

Is the service caring?
The service was caring.

Staff understood how to treat people with dignity and respect and were confident people received good quality care.

People were supported by staff who treated them with kindness.

People's right to privacy and confidentiality was respected.

Good

Is the service responsive?
The service was not always responsive.

Some care records had gaps and omissions that could lead to people's needs being missed or overlooked.

People who used the service and their relatives said they would like more activity at the home.

There was a clear procedure to follow should a complaint be raised.

Requires improvement

Is the service well-led?
The service was not consistently well- led.

Requires improvement

Summary of findings

Systems in place to monitor and assess the quality of service provision were not always effective.

People spoke highly of the registered manager and management team.

Newfield 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.

This inspection took place on 27 May 2015 and was unannounced.

At the time of our inspection there were fifty eight people living at the service. During our visit we spoke eight people who used the service, three relatives, fourteen members of staff which included the manager and area manager. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at five people's care records and six people's medicine's records.

The inspection was carried out by two adult social care inspectors, a specialist advisor in governance, a specialist advisor in medicines, a specialist advisor in dementia and an expert-by-experience who had experience of older people's care services and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and notifications. We contacted the local authority and Healthwatch. We were not aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires improvement

Is the service safe?

Our findings

Several people who used the service and their relatives said they did not think there were enough staff to meet the needs of people who used the service. One relative said, "We're very happy with how they're looked after. I just wish there were more staff. The girls are wonderful. They're very dedicated, but there's only so much they can do. A lot of people need two people to help with the loo, so there's no one else left for the others." Another said, "The girls do their best, but they're really stretched and they're not even full at the moment." People who used the service said they tried not to ring their call bells at night as there were not enough staff to cover. Another relative we spoke with said, "I would like a third member of staff up here, (Dementia unit) they are often left with one person due to having to take their breaks. Staff don't always cover from other floors, I feel this has been done today for your benefit" and "Sometimes a senior carer is placed on duty on here but then gets called away to do their medications leaving one member of staff on the unit."

We saw in a survey completed in March 2015 a relative had said, "There are several residents on the dementia unit that require high dependency and require two carers at least to give proper care. The practice of having one carer with a senior is flawed and unsafe, especially when the senior has to do medications on another unit leaving one carer looking after 16 residents. Employ more staff!" They had also said their relative was unable to take a bath at the time they wanted one.

Our observations showed that there were periods of time when the communal areas were left unsupervised. On one occasion we saw people who used the service were involved in 'low level' argumentative type conversation which could have led to more serious altercation. During the lunch service we observed a verbal altercation between two people who used the service. One staff member had left the unit for a short time but no cover had been sent to cover this absence. The staff member was trying their best to manage this altercation however they did struggle as other people then began to contribute their opinions. Eventually, the member of staff did de-escalate the situation, however this was a key example of a situation that could have got out of hand very quickly and there was nobody available to assist the staff member to manage it. We also saw during the evening that night staff were busy providing care to people in their rooms and the lounge areas were not supervised. We observed on one occasion that two people who used the service were anxious as they could not find staff to assist them. One person wanted to go outside for a cigarette; the other person had attempted to open a can of beer and had broken the ring pull which they could have cut themselves on. There were no staff available to assist these two people. We had to ask a staff member who was going off duty to support them.

Most staff we spoke with said they did not think there were enough staff to meet people's needs fully. They said that two staff during the day on the residential units were enough but that the increased dependency of people living on the dementia units meant that two staff was not enough. Staff's comments included; "Some days, some residents need that bit more attention, sometimes you could do with a floater" and "I think they could do with a few more [staff] a lot of people leave and as fast as they're trained, they're going." Staff said that the impact on people living in the home was that there were times when they were left unsupervised when two people were needed to support a person, especially at the start of the night shift. Staff said that the support of the manager or deputy manager did not help as they did not provide 'hands on care' and were either busy in the office or administering medication. We were told that maintenance and domestic staff were sometimes asked to provide supervision of communal areas. We were told they were trained to do this but did not provide personal care.

Our review of notifications received from the service showed there had been 15 safeguarding notifications received since the last inspection of the service in September 2014 which involved altercations and incidents between people who used the service that had been reported to the local safeguarding authority. We looked at the falls records in the home and saw there had been 28 falls recorded in March 2015; 21 were unwitnessed and 38 falls in April 2015, of which 26 were unwitnessed. We saw an audit of falls had been completed in March 2015 where it was recorded 'staff levels have been reviewed and are due to increase to ten ensuring additional carer covers ground floor during the day'. We did not see evidence that staffing levels had been increased as stated.

We discussed care staffing levels with the registered manager. We were told that there should be eight staff and a deputy manager through the day and four staff and a

Is the service safe?

deputy manager at night. We looked at the staff rotas for the last three weeks and saw staffing was provided as the manager had described most of the time. However, there were seven occasions when the rota showed they had been short staffed on day shifts and three occasions when short staffed on nights. We did not see any evidence that staff numbers had increased to ten on days as described above. We were told that this was in response to reduced occupancy in the home and would be increased when the home had a greater occupancy. The registered manager told us they regularly completed a dependency tool to work out the staffing levels in the home. We looked at the 'dependency statistics summary' and saw this considered factors such as falls risks, mobility and support needed with personal care. However, the information did not show how staffing numbers needed to keep people safe were identified from this dependency assessment.

We concluded that there were not at all times, sufficient, suitably competent staff deployed to ensure people's needs were met safely and that people were properly supervised to ensure their safety. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

Overall, people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. We observed medicines administration to six people who used the service and noted that there was a good rapport between people and the staff and that all necessary procedures and records were carried out. We examined the Home's Medicines Management policies and procedures and found them to be comprehensive and appropriate.

A sample of Medicines Administration Record (MAR) forms were looked at on each of the four units as well as examination of systems in use for medicines procurement, storage, administration, disposal and record keeping. Overall, MARs were correctly completed and medicines were correctly obtained, stored, administered, recorded and disposed of. We noted that one bottle contained an oral medication called Methotrexate which was correctly labelled as being 'cytotoxic'. We advised the staff and registered manager that the person administering the medication should wear disposable gloves which should be changed after administration to protect staff and prevent the possibility of cross contamination of other medication.

Staff told us that there were four medicines rounds per day and we noted that records were kept to ensure that doses of paracetamol were not administered within four hours of each other. We noted that separate records were kept for administration of creams and ointments by care staff who then made the appropriate record in the MAR. We saw that one person had been receiving medicines covertly and we examined the relevant documentation which showed that all correct procedures had been followed. We spoke with a person who managed their own medication who told us that they had no problems with managing her own medicines and that the staff were very helpful and kind.

We inspected the clinic rooms and found that all cupboards were locked with the exception of the refrigerator on the first floor which was unlocked albeit within a locked room. Temperature records for the refrigerator on the ground floor were recorded daily on the log and showed that all temperatures were within limits. Staff also recorded the room temperature daily and this was also within limits. However, the records for the refrigerator on the first floor were marked 'n/w' which we were told meant 'Not Working'. Records showed that this had been the case since January 2015. The refrigerator contained medication that we were told was not in use, however, we advised the manager that the contents of the refrigerator should be correctly disposed of and the refrigerator removed from use until the fault had been repaired to ensure medicines were stored safely at the correct temperature. The registered manager could offer no explanation as to why the refrigerator had not been repaired or replaced.

We looked at the records of controlled drugs (CD's) in the home. We found five entries which did not match with physical stock. We also noted that the index to the book was not being used correctly with several page entries which did not match with pages in use and that the index page itself was partly torn and difficult to read. The registered manager was immediately informed of our findings and was subsequently able to demonstrate that each of the five incorrect entries related to stock which had been returned to the pharmacy for disposal and that there were entries in a separate 'Returns' book to verify this. We

advised the registered manager that any returns must be recorded in the CD Register and that a new CD Register be obtained to replace the current one which was untidy and contained a torn index page. This was done on the day of our visit.

People who used the service said they felt safe and we saw positive interaction between staff and people who used the service throughout our visit. People appeared happy and comfortable with the staff. Relatives told us that they felt confident that their relative was safe and well cared for.

Appropriate recruitment checks were undertaken before staff began work. These checks helped to make sure job applicants were suitable to work with vulnerable people. We looked at the recruitment process for four members of staff and saw this was properly managed.

We spoke with staff about their understanding of protecting vulnerable adults. Staff had an understanding of safeguarding adults, could identify types of abuse and most knew what to do if they witnessed any incidents. Staff were aware of Whistleblowing and said that they had never had need to whistle blow but would have no hesitation in reporting anything if they had concerns. Staff told us they had received training in safeguarding vulnerable adults. The home had policies and procedures for safeguarding vulnerable adults and these were available and accessible to members of staff. There were effective procedures in place to make sure that any concerns about the safety of people who used the service were appropriately reported.

We carried out an inspection of the premises and equipment used in the home. We saw that the home was overall, clean, tidy and homely. There were no malodours in the home. There was one domestic on duty from 9am-5pm for the whole home and daily tasks included all bedrooms and en suite facilities. They explained the procedure for undertaking a deep clean and were clear about the process for cleaning during an outbreak of diarrhoea and vomiting which they said had occurred recently. There were cleaning schedules in place. We noticed a chair had been left damp after spot cleaning. We brought this to the attention of staff who turned the chair cushion over meaning it may not have air dried properly.

We found that a number of toilet seats in the home looked unsightly and stained. The registered manager said this had been identified and new ones were on order. We saw some arm chairs in communal areas had stained chair arms and seemed grubby in places. The registered manager said they were aware some needed to be replaced and would make arrangements to have them checked. We observed staff carrying out good hygiene practices such as food preparation. We saw that equipment such as wheelchairs, bath chairs, hoists and commodes were clean. We saw there was adequate provision of suitable hand washing and drying facilities in all areas of the home and staff showed good knowledge and awareness of their responsibilities for infection prevention and control and the use of personal protective equipment.

We looked at window restrictors on a random sample of windows in the home. We found them to be in place where needed, locked and were told regular checks were carried out to ensure their safety. The area manager said the provider was aware of the latest guidance from the Health and Safety Executive regarding window restrictors. However, we noted that the window restrictors had an override facility which meant they could be opened wider than the recommended 100mm. The area manager said their health and safety department were going to visit the home the day after our inspection to assess the safety of the window restrictors to make sure they complied with the latest guidance.

Records showed there had been no maintenance person in the home during September and October 2014. During this time maintenance checks such as fire safety checks, health and safety checks, water temperatures and window restrictors were not carried out. The registered manager confirmed there had not been anyone else available to carry out the checks. This left the safety of people who used the service at risk. A maintenance person was now in place and a schedule of checks was completed. The registered manager provided all maintenance certificates, which were up to date, however the documentation provided regarding lifting equipment showed the last date of checking to be in 2012 for one hoist. We discussed this with the registered manager who said the hoist had been checked annually and they would follow up why that certificate was not on the premises.

We reviewed personal evacuation plans for people who used the service. These plans detailed what safety measures were needed to evacuate each person individually in the event of an emergency. Staff could describe the action they needed to take in the event of a fire in the home. We were told that night staff had not had

Requires improvement

Is the service safe?

chance to participate in a fire drill recently. We informed the manager of this. A business continuity plan was provided and identified that people who used the service would be transferred to another of the provider's homes temporarily in the event the home became inhabitable.

We observed staff assisting in the moving and handling of people who used the service. On the whole, these tasks were undertaken safely in accordance with national policy; however there was one occasion, when we observed an unsafe moving and handling task. We drew this to the attention of the registered manager who agreed a re-assessment was needed for this person.

Requires improvement

Is the service effective?

Our findings

Throughout our inspection we saw that people who used the service were able to express their views and make decisions about their care and support. People were asked for their choices and staff respected these. For example, people were asked where they wanted to sit, where to eat

their meals and what to eat or drink. In addition we saw staff sought consent to help people with their needs.

However, care records we looked at did not show how people or their family had been consulted over decisions such as reduction in alcohol consumption or carrying out of room checks. We did not see any consent records had been signed by people who used the service to show they were in agreement with decisions made about their treatment and support. And in one person's care records we saw that their relative had signed the consent and risk management plans despite the person who used the service being assessed as having the capacity to consent to their own decisions. This means there was a risk that people were receiving care interventions they had not consented to and that this was against their wishes or individual preference.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager informed us they had identified a number of people who used the service as being deprived or potentially being deprived of their liberty. We were told there were five people with DoLS in place and they were working with the local authority regarding further applications and were currently awaiting the outcome of a number that had been submitted. Staff we spoke with were unclear as to who had a DoLS in place. One staff member, when asked if there was anyone with a DoLS in place said, "No we don't, there used to be someone but they moved to a different home". Another staff member said there was one person with a DoLS in place. This indicated that the provider had not fully explained DoLS to staff and communicated who was living at the service under a DoLS authorisation to ensure people's rights were respected.

We looked at care records in relation to the assessment of the mental capacity of people who used the service. We saw that the assessment documentation was comprehensive and followed the guidance of the Mental Capacity Act 2005 (MCA). However, in two people's assessments we saw contradictory information regarding their capacity to make decisions. It was recorded that people did and did not have capacity in the same document. This was unclear and did not follow the principles of the MCA.

Staff were aware of the MCA but were not all confident talking about what it meant. They were aware that people may lack capacity to make some decisions and spoke about what they did to help people make day to day choices such as what to wear or eat and drink. One staff member said that if a person had a diagnosis of dementia or other health need, they would need to receive a mental capacity assessment before they were presumed to lack capacity, especially if they were making decisions. However, another staff member did not refer to MCA assessments and said "I would know if they were not in their right mind." This demonstrated that not all staff had an understanding of mental capacity.

The above evidence demonstrated a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

Staff we spoke with confirmed that they had access to training and were paid to complete this either on a face to face basis or on line. One staff member described the induction training that they had recently undertaken and said this included safeguarding, Mental Capacity Act (MCA) and Deprivation of liberty safeguards (DoLS), moving and handling, infection control, food hygiene and emergency first aid. In the four files that we looked at for staff appointed since Jan 2015, all staff had undertaken the induction which had lasted two and a half weeks. Certificates were in place in the file. However, each of the four files contained a blank 18 page induction booklet which was to be completed throughout the 6 months' probation period. All these booklets had the name of the staff on the front but there was no other information. The date of starting and the name of the new starter's mentor had not been filled in. Initial information about the home which would need to be discussed in the first few days had not been completed to show what had been covered in the induction period.

We spoke with a new staff member who confirmed they had completed an induction programme, had spent a day

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working alongside an experienced staff member and felt confident in their role as a care worker. We asked staff specifically about the training in dementia that they had undertaken. Most staff had undertaken dementia awareness training as part of their induction and mandatory training. When we asked what this included they said that they had learnt about different types of dementia and what to do to manage challenging behaviour. They described the need to talk with the person and to try and calm them down, to distract them and try and walk away from a situation to a different area of the unit as techniques to support people. We saw staff also demonstrated this good practice.

There was a rolling programme of refresher training available which included safeguarding vulnerable adults, dementia awareness, food hygiene, fire training, health and safety and infection prevention and control. However, when we looked at the home's training matrix we saw that over half of the staff team had not received their mandatory refresher training in these subjects to ensure their practice was current. The registered manager was aware of this and showed us documentary evidence of the plan in place to ensure all mandatory refresher training was completed by November 2015.

We saw that medication training had been completed by staff who were responsible for the administration of medication. We also saw a competency check had been completed for one staff member following their training and there were plans in place for other staff to receive this from the home's pharmacy suppliers.

People who used the service said that they liked the staff and that they felt that they were competent and well trained, but that there were not enough of them.

Staff described their supervision sessions and said that these were about every six weeks and included discussions about training undertaken, the needs of people living in the service and specific concerns they might have. We saw there was an electronic supervision matrix in place which gave reminders and alerts when supervision meetings were due. We looked at individual supervision records for four staff. The records were detailed and included opportunities for the staff to comment on their work and any issues. We also saw the records included plans for performance improvements where needed. We did however, see that there was no record of any follow up action taken to address a performance issue for one staff member. It was unclear if the issue had been resolved. The registered manager said that some records still needed to be filed and was aware of the current situation.

Staff said they got good support and expressed their appreciation for the registered manager. One staff member said of the registered manager and deputies, "They're absolutely fantastic, if you want advice they'll give it."

People who used the service said they liked the food. Comments we received included; "Delicious, the food's always good here", "This is nice" and "We haven't had a bad meal yet have we". We looked at the four-weekly menu. There was plenty of choice of food and drink.

We observed the lunch time meal in three dining areas of the home. We observed positive, polite interactions between the staff and people who used the service. We saw there were photo cards of the day's menu on the wall to assist people to make choices. Staff asked people individually what they wanted, including each vegetable. However, in one dining area there was not a choice of cold drinks and staff just asked if apple juice was 'ok'. The food looked appetising and good portions were served. We saw staff were encouraging with people who used the service and offered appropriate assistance. At the end of the meal people were asked if they would prefer tea or coffee. We noted tables were laid with flowers, table cloths and looked clean and attractive. The mealtime service was a positive, social and unhurried event for people who used the service.

The cook was aware of the specific dietary needs of people who used the service, however, these were not written down which could lead to a risk of these needs being overlooked. They gave examples such as soft diets, blended diets and those who have reduced sugar. Staff were able to describe who had thickener in drinks and why this was used.

We reviewed the care plans of two people who were deemed at nutritional risk. They were both assessed as needing to be weighed on a weekly basis. However both people had not been weighed since 10th May 2015. This was documented as "scales charger is broken, manager aware, awaiting repair." The registered manager agreed to follow up this repair. We also saw for one person that fluid and food intake diaries were in place. However, these were

Requires improvement

Is the service effective?

not always completed which meant there was a risk that their nutrition and hydration needs may not be properly met. The registered manager agreed to ensure these were reviewed.

Records showed that arrangements were in place that made sure people's health needs were met and that people had access to external health professionals and were supported to maintain a good status of health. Entries in the care documentation evidenced that referrals were appropriate and made in a timely manner. Issues were followed up on swiftly. There was clear involvement from the GP, dietician and Speech and Language Therapist (SALT) where appropriate.

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke with all told us that they felt that the staff were caring and supported them or their family member very well. One relative said, “We feel that they are very well looked after.” The interaction between staff and people who used the service appeared relaxed, staff were happy, smiling, and friendly and people who used the service appeared to respond to them well. People who used the service enjoyed the relaxed, friendly communication from staff. Throughout the visit we observed staff speaking to people in a friendly and respectful manner. Staff took the time to stop and chat to people and respond to comments made. It was clear they knew people well. Relationships that we observed between the staff and relatives of people who used the service also seemed friendly and positive.

On one occasion we saw staff were talking to people about holidays and how they had liked to spend them. One person was talking about how they enjoyed going camping and due to their dementia could not place the word ‘tent’ when describing what they stayed in on their holiday. The person began trying to describe a tent to others involved in the conversation and after listening intently for a few moments, one of the members of staff brought out a picture of a tent and said “Is this what you are describing for us?” to which the person responded “Yes that’s right we stayed in one of them”. This showed a patient, encouraging and caring approach from the staff member.

We also saw that during lunch, one person who used the service became tearful and upset. A member of staff went over and sat with her arm around the person, reassuring them. The staff member stayed with the person offered them a cup of tea and the person brightened up considerably and went on to finish their lunch.

People’s right to privacy and confidentiality was respected. All records belonging to them were locked away in an office only accessible by staff. People’s rights to be treated as an individual were respected; bedrooms were seen to contain possessions owned by the person to whom it belonged, people were clean, dressed in appropriate, clean clothing and were taken to their room and assisted to change if required by staff at frequent intervals throughout the day to ensure their dignity was maintained.

When we spoke with staff they were all able to describe what person centred care meant and said that they treated all people as individuals. They were able to describe how individual care needs were met and gave good examples of person centred care. Staff explained their key worker role and what their responsibilities entailed, for example, making sure people had all the toiletries they needed and that clothing and wardrobes were kept tidy.

We looked at care planning and reviews and the involvement of people who used the service and their relatives in the care planning process. We found that in some cases, reviews had been undertaken with family involvement however there was no evidence that people who used the service had been consulted in relation to planning their care and in some cases there was no documented involvement from the relatives. It was written in some care plans however; under the care plan for social needs ‘involvement of family is important to (name of person)’. We spoke with the registered manager and area manager about this and they said they had written to relatives and were planning to discuss the issue at residents/relatives meetings to try and get people more involved and engaged in the care planning process. One relative said “I don't really get involved in care plans. She's been here such a long time, but if I have any worries, I talk to the staff. If it's serious I'll go to the manager.”

Relatives and friends of people who used the service said they could visit at any time. One relative said, “We can come and go whenever we want, apart from the protected mealtimes, which is fine. It's important that people can eat in peace.”

The registered manager told us that no one who lived in the home currently had an advocate. They were however, aware of how to assist people to use this service. There was information available in the home to assist people to obtain an advocate from a local organisation.

Some people who used the service had ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) documentation in their care files. We noted that the person had their wishes documented on an out of date version of this document which meant their wishes may not be adhered to. The registered manager agreed to review all the DNACPR documentation with the GP of people who used

Good

Is the service caring?

the service to ensure the correct and valid form was in use. After the inspection we were informed that the service contacted people's GP and were told the forms were still valid.

Requires improvement

Is the service responsive?

Our findings

Records showed that people had their needs assessed before they moved into the service, however we noted the information was not always detailed enough to ensure people's needs were thoroughly communicated or recorded.

We looked at the care records for five people who used the service. We saw these were individualised to the abilities of the people who used the service. We saw that people's preferences in relation to whether they would like a bath or a shower had been documented however, there was no clear evidence these preferences were being supported. We asked staff and they said people who used the service had a daily shower and a weekly bath if that was their preference. There was no documentary evidence of this support given. However, people who used the service did appear clean and well-groomed on the day of the inspection and had no concerns about their personal care.

We saw care plan evaluations were up to date; however, it was difficult to find the most up to date evaluation of care as it was not kept with the care plan. This could lead to confusion and mean people's needs may be missed or overlooked. We saw information relating to likes and dislikes and preferences in general was lacking, for example, care plans relating to activities and social interests were not very detailed when completed and in some cases this particular care plan was blank altogether meaning people's social needs were not available to guide staff. One person's care plan stated they had a medical condition and staff needed to be aware of the symptoms. The symptoms were not listed in the care plan and staff we spoke with did not know what they were. This could lead to the person's needs being missed.

One care plan we looked at had clear plans in place regarding the management of behaviours that challenged the service. Recording charts for incidents where this person's behaviour had escalated, commonly known as ABC charts were in place and completed fully and there was evidence confirming the involvement of the community mental health team and GP. This showed that the service was responsive to people's needs and worked with external professionals to keep the people who used the service safe from harm and distress. We also looked at some end of life care planning documentation. We saw for one person there was good, person centred information on how they wish to be cared for as the end of their life approached. This showed great consideration of the person, their family and their wishes.

The registered manager said care records would be reviewed to ensure they were better organised and provided enough detail on the care needs of people who used the service. Staff said that care plans gave up to date information on people's needs. They said they read the care plans when they had time and used these along with handovers to inform their knowledge of people's needs. A new member of staff said they had had time to familiarise themselves with a number of care plans and could talk about the specific needs of people who used the service.

Throughout the day, apart from the television and relatives visiting, we did not observe any specific social activity. People were chatting with each other on the residential unit on the ground floor and although the television was on for the whole day there was a small group of people who sat round away from the television and chatted to each other. We heard one person say to another, "I'd love it if someone would take me out, I wouldn't care where, I'd go anywhere." People spoke positively about the home and said they liked living there but also said there was not much to do. One person said, "I can't fault it. I'm very content. I feel safe, but there is nothing to do."

Staff said they got involved in the provision of activity such as sing-a-longs and quizzes. We looked at some of the activity records and saw that there were entries by staff which recorded what each person had done during the day. The majority of entries stated. "[Name of person] has relaxed in front of the TV today." There were some entries which included visits from relatives, watching a film, enjoying an entertainer who had visited the home. Staff said that people on the residential units enjoyed occasional activities but preferred to chat and watch TV and were not always keen on games and arranged activities. A relative of a person who used the service told us; "There should be more staff and more activities though, and a dedicated activities co-ordinator. There's not much going on".

The home had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. Comments and complaints people made were responded to appropriately. A relative of a person who used the service said they had

Requires improvement

Is the service responsive?

complained to the registered manager about various issues and they had responded to them appropriately. Another relative said “Whenever we've brought up issues, we're listened to and we can see that it's acted upon. We feel listened to.” The complaints policy and procedure was up to date and displayed in the reception area of the home on the wall.

We reviewed recent complaints received by the home. Twenty complaints had been received since our last inspection of the service in September 2014. We saw the majority of these related to staffing concerns within the home. Records showed that the registered manager had followed the complaints procedure for all complaints recorded. The complaints were responded to in a timely manner. Where staff were involved the complaint showed the staff member was spoken to by the registered manager and all staff were made aware of the outcome, showing a commitment to learning from concerns. Head office and the area manager were involved where appropriate.

There were no outstanding complaints at the time of the inspection. The area manager told us they had recently held a meeting with the relative of someone who used the service, who had voiced concerns about the dementia unit often being unattended, during the meeting an action plan was agreed and they were due to meet with them again in three months’ time to review the situation. The area manager said they had increased staffing levels in response to these concerns raised. However, we were told that due to reduced occupancy these staffing levels were not currently being worked, therefore it was unclear if the person’s concerns had been addressed.

There was evidence of staff meetings taking place monthly. Issues about the home were discussed in these meetings some of which were regarding the quality of care in the home. Concerns were discussed with staff in order to prevent re-occurrence of issues and drive improvements in the service. Staff confirmed there were staff meetings and that the registered manager had a list of things to discuss and then staff could add things to the agenda. Most staff said that they could speak up freely.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a team of deputy managers and care staff. The registered manager supervised the care given and provided support and guidance where needed. People who used the service said they knew who the registered manager was and that she was always available if they ever had any problems.

Many of the staff we spoke with said that they felt supported and could talk with the managers. All the staff we spoke with said that they really enjoyed the work and got great satisfaction from the work supporting the people who lived in the service. Staff demonstrated a pride and commitment to their work. Comments included; "I love it, I'd never worked in a care home before, and I was petrified, it was daunting. Sometimes they're having bad days but every day's different." Staff told us they felt valued and appreciated. One said, "Its good team work, and I feel I can go to them [managers] at any time." Staff said they understood the registered manager was fairly new in post. One said, "[Name of manager] tries hard to support staff." Another said, , "I take my hat off to [Name of manager], she's put her heart and soul into some staff." Staff said the registered manager had made improvements to the way the service was managed since they had been in post.

Some staff raised concerns about teamwork in the service and said there was a 'divide' between the day staff and night staff and this could lead to care not being delivered properly and mistakes being made. We discussed this with the registered manager who said they were aware of the situation, had plans in place to address this and were planning to introduce spot checks. Our observations on the day of the visit showed that staff were working as a team, communicating well with each other to make sure people's needs were met.

We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the home. Staff said they felt the registered manager would act upon any concerns that they raised. One said, "The manager is always visible", she is always floating around somewhere, the manager is absolutely lovely and leads the home well."

People who used the service and their relatives were asked for their views about the care and support the service offered. On display in the home there were actions from a recent residents meeting where issues and ideas had been discussed. This showed that people who used the service had said they wanted a 'pub' setting up in the home. We saw this had been addressed and a room had been dedicated for this and was in the process of being set up with a bar and taps, plus easy chairs, games and a television for watching sports and other events. People had also said that they wanted the existing 'cake shop' in the home to become a 'local shop', selling more than just cakes. We were told this was planned. Whilst it was clear that action was taken to improve the service for people, some suggestions such as more bingo and more trips out were recorded as being 'discussed', 'considered' or 'reviewed'. It was not recorded what action would be taken to ensure this happened.

We saw that a guest book, surveys and questionnaires were used to monitor the experience of people who used the service. There was evidence of feedback on questionnaires and this was displayed on notice boards in the home. We saw there was overall, a high degree of satisfaction with the service. Comments in the guest book included; 'Very clean and all staff helpful' and 'Highly recommendable, Mum looks very happy and well'. All entries in the book showed that people had stated they were extremely likely to recommend the home.

A survey showed that a relative had raised concerns about staffing levels on the dementia unit. There was evidence that the area manager had attended a meeting with the relatives to discuss this. We saw the registered manager offered a 'drop-in' surgery for relatives, every Tuesday 4pm -7pm. This was advertised throughout the home.

The registered manager and area manager told us there was a system of a continuous audit in place. This included audits on health and safety, care issues and documentation, complaints, incidents, falls, safeguarding, fire safety and infection control. We noted that medicine audits were carried out at monthly intervals by a senior manager and that action plans were prepared and followed up at regular meetings with staff. We saw accidents and incidents were audited for any patterns or trends and appropriate referrals were made in response to them.

We were told that any actions identified through these audits were then developed into an action plan with the registered manager with time-frames for completion. We

Requires improvement

Is the service well-led?

saw documentary evidence that these were in place. However, we noted that issues we had picked up through our inspection had not been identified. For example, the number of complaints regarding staffing levels had not been identified as a trend, no arrangements had been put in place to ensure safety checks were completed when there was an absence of a maintenance person and no action had been taken to repair a drugs refrigerator in a timely manner. There were no records of spot checks on cleaning carried out in the home or records that showed the cleaning schedules had been audited. All of which increased the risks to people's care and safety. The registered manger agreed to ensure there was a review of how audits and checks were carried out.

The manager and staff said the service was checked regularly by the provider. They said the area manager was a frequent visitor to the home and always asked for feedback on the service from staff and people who used the service. Staff said they were kept informed of important information in the home, any changes and any concerns that were raised. They said they had good, thorough daily handovers to ensure this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not at all times, sufficient, suitably competent staff deployed to ensure people's needs were met safely and that people were properly supervised to ensure their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent, the provider did not always act in accordance with the legal requirements of the MCA 2005. People's consent to their care and treatment was not always recorded.