The Elms Residential Home Limited

The Elms Residential Home

Inspection report

111 Melbourne Road
Ibstock
Leicestershire
LE67 6NN
Tel: 01530 260263

Date of inspection visit: 6 January 2016
Date of publication: 15/02/2016

Ratings

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

Overall summary

We inspected the service on 6 January 2016 and the visit was unannounced.

At the last inspection on 10 November 2014 we asked the provider to take action to make improvements. We asked them to improve their practice in relation to the arrangements for monitoring the quality of the service and delivering improvement. We also asked the provider to improve their practice in relation to obtaining people's consent to care. Following that inspection the provider sent us an action plan detailing what they were going to do to make improvements. We found that although improvements had been made to monitoring the quality of the service, the provider had still not fully considered people's consent in line with the Mental Capacity Act 2005. You can see what action we told the provider to take at the back of the full version of the report.

The Elms Residential Home provides residential care for up to 18 older people. There were 18 people using the service at the time of our inspection, the majority of whom were living with a dementia-type condition. The

Summary of findings

accommodation was provided over two floors and there was access to the upper floor via a passenger lift or stairs. There was a large accessible garden that people could use.

It is a requirement that the home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection there was a registered manager in place.

People told us that they felt safe. Staff were aware of how to keep people safe through the training they had undertaken and knew how to report actual or suspicions of abuse.

Risks to people had largely been addressed and documented but the records sometimes lacked detailed information for staff to follow. We found that people did not always have a call bell available to help them to keep safe.

The home and equipment were being regularly checked so that people were safe. However, some records were not always up to date to verify this. Some plans to evacuate people from the home if needed were not always complete.

Staffing levels were appropriate to keep people safe during our visit. Feedback from relatives and staff members suggested that staffing levels needed to be looked at during the night. Recruitment of new staff was robust and the registered manager had carried out checks on prospective staff before they worked for the provider.

People received the medicines that they needed. We saw that there were systems and policies in place to make sure medicines were being handled safely.

We saw that staff members had received regular training, including dementia training, which was important for the people they offered support to. However, we found that best practice in relation to dementia care and support was not always in place.

People were given choices regarding food but sometimes these were in ways that they could not understand.

People's consent to care had not been fully considered. Where people may have lacked the capacity to make decisions for themselves, the provider had not made arrangements for appropriate mental capacity assessments to be undertaken. We also saw that decisions made in a person's best interest had not been documented. We found that staff had undertaken training in the Mental Capacity Act 2005 but they did not show a good understanding of this legislation. We identified that these matters constituted a breach of the regulation where there service had failed to act in accordance with the provisions of the Mental Capacity Act 2005.

People enjoyed the food offered to them. However, where people were receiving a soft diet it was not clear whether this was a person's preference or if the home had put this in place.

People had access to a GP when required and we found that people received regular support from a chiropodist and dentist.

People told us that the staff were caring. We saw that staff offered support in a kind way. However, we found that staff did not spend quality time engaging with people and focused mainly on practical tasks.

People's preferences were detailed in their care plans and we found things that were important for people to be in place. For example, a person's preferences for their bedding had been addressed by staff.

Records did not show how people had been involved in decisions about their care. Relatives had not always been invited to be involved in their family member's care planning.

People were largely receiving the care they required in line with their care plans. For example, people were being assisted to turn to prevent pressure ulcers from developing. However, where soft diets were given, these had not been carefully care planned.

People's care plans were being reviewed regularly to give staff up to date information about people. However, the reviews did not identify incorrect information.

People had mixed views on the activities being offered. We found that the planned activities did not all happen on the day of our visit.

Summary of findings

People felt listened to and knew how to make a complaint if they needed to. The registered manager had dealt effectively with any complaints received.

The registered manager had audited the service regularly. However, the audits had not identified what we found on the day of our visit. For example, we found call bells were not available to some people.

Staff told us that they felt the registered manager was approachable and that they felt supported. We saw that the registered manager offered guidance and support to staff members.

There was a shared understanding within the staff team about what the service strove to achieve which was high quality care.

Relatives had mixed views about whether the provider had sought feedback on the service. Where it had been sought, the results of the quality assurance process had not been shared.

The registered manager was aware of their role and responsibilities and made the correct notifications to the relevant authorities.

We inspected the service on 6 January 2016 and the visit was unannounced.

At the last inspection on 10 November 2014 we asked the provider to take action to make improvements. We asked them to improve their practice in relation to the arrangements for monitoring the quality of the service and delivering improvement. We also asked the provider to improve their practice in relation to obtaining people's consent to care. Following that inspection the provider sent us an action plan detailing what they were going to do to make improvements. We found that although improvements had been made to monitoring the quality of the service, the provider had still not fully considered people's consent in line with the Mental Capacity Act 2005. You can see what action we told the provider to take at the back of the full version of the report.

The Elms Residential Home provides residential care for up to 18 older people. There were 18 people using the service at the time of our inspection, the majority of whom were living with a dementia-type condition. The accommodation was provided over two floors and there was access to the upper floor via a passenger lift or stairs. There was a large accessible garden that people could use.

It is a requirement that the home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection there was a registered manager in place.

People told us that they felt safe. Staff were aware of how to keep people safe through the training they had undertaken and knew how to report actual or suspicions of abuse.

Risks to people had largely been addressed and documented but the records sometimes lacked detailed information for staff to follow. We found that people did not always have a call bell available to help them to keep safe.

The home and equipment were being regularly checked so that people were safe. However, some records were not always up to date to verify this. Some plans to evacuate people from the home if needed were not always complete.

Staffing levels were appropriate to keep people safe during our visit. Feedback from relatives and staff members suggested that staffing levels needed to be looked at during the night. Recruitment of new staff was robust and the registered manager had carried out checks on prospective staff before they worked for the provider.

People received the medicines that they needed. We saw that there were systems and policies in place to make sure medicines were being handled safely.

We saw that staff members had received regular training, including dementia training, which was important for the people they offered support to. However, we found that best practice in relation to dementia care and support was not always in place.

People were given choices regarding food but sometimes these were in ways that they could not understand.

Summary of findings

People's consent to care had not been fully considered. Where people may have lacked the capacity to make decisions for themselves, the provider had not made arrangements for appropriate mental capacity assessments to be undertaken. We also saw that decisions made in a person's best interest had not been documented. We found that staff had undertaken training in the Mental Capacity Act 2005 but they did not show a good understanding of this legislation. We identified that these matters constituted a breach of the regulation where there service had failed to act in accordance with the provisions of the Mental Capacity Act 2005.

People enjoyed the food offered to them. However, where people were receiving a soft diet it was not clear whether this was a person's preference or if the home had put this in place.

People had access to a GP when required and we found that people received regular support from a chiropodist and dentist.

People told us that the staff were caring. We saw that staff offered support in a kind way. However, we found that staff did not spend quality time engaging with people and focused mainly on practical tasks.

People's preferences were detailed in their care plans and we found things that were important for people to be in place. For example, a person's preferences for their bedding had been addressed by staff.

Records did not show how people had been involved in decisions about their care. Relatives had not always been invited to be involved in their family member's care planning.

People were largely receiving the care they required in line with their care plans. For example, people were being assisted to turn to prevent pressure ulcers from developing. However, where soft diets were given, these had not been carefully care planned.

People's care plans were being reviewed regularly to give staff up to date information about people. However, the reviews did not identify incorrect information.

People had mixed views on the activities being offered. We found that the planned activities did not all happen on the day of our visit.

People felt listened to and knew how to make a complaint if they needed to. The registered manager had dealt effectively with any complaints received.

The registered manager had audited the service regularly. However, the audits had not identified what we found on the day of our visit. For example, we found call bells were not available to some people.

Staff told us that they felt the registered manager was approachable and that they felt supported. We saw that the registered manager offered guidance and support to staff members.

There was a shared understanding within the staff team about what the service strove to achieve which was high quality care.

Relatives had mixed views about whether the provider had sought feedback on the service. Where it had been sought, the results of the quality assurance process had not been shared.

The registered manager was aware of their role and responsibilities and made the correct notifications to the relevant authorities.

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 consistently safe.

Requires improvement

People told us that they felt safe.

Staff were able to describe the signs of abuse and knew what to do to report their concerns.

Risks to people had not always been addressed and where equipment was being checked to keep people safe, records did not always reflect this.

Medicines were being handled safely.

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

Requires improvement

Staff had received training and regular support from the registered manager to help them to provide effective support to people. Staff had received dementia training but staff were not always working to best practice when supporting people with this condition.

The provider was not meeting the requirements of the Mental Capacity Act 2005 and staff's understanding of this legislation was limited.

People had access to healthcare services.

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

Requires improvement

People were supported in a kind way but sometimes staff had not respected people's dignity.

People's preferences were recorded and acted upon.

Records did not show how people, or significant others on their behalf, had been involved in planning their own care.

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

Requires improvement

People did not always receive care and support that was based on their individual needs.

Summary of findings

People's independence was encouraged by staff members.

There were activities available but these were not always occurring.

People knew how to raise a complaint and the registered manager had effectively dealt with the complaints received.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Internal monitoring and assessment of the service was not robust.

Relatives and staff felt that the registered manager was approachable and staff felt supported.

There was a system in place for the provider to seek feedback from relatives about the quality of the service. However, the results had not been shared.

There was a registered manager in place who was aware of their responsibilities.

The Elms Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 6 January 2016 and was unannounced. The visit was carried out by two inspectors. Before the inspection we reviewed information that we held about the service to inform and plan our inspection. This included statutory notifications which include information from the provider about significant events that they are required to tell us about in law. We also spoke to the local authority to gain their current view of the service.

We spoke with four people who used the service and four relatives. We spoke with the registered manager, three care staff and a senior member of the care team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of three people who used the service along with other documentation to see how the service was being managed. This included records in relation to health and safety, training and medicines management. We also looked at the support that staff received from the registered manager and recruitment processes.

Requires improvement

Is the service safe?

Our findings

People living at the service told us that they felt safe. One person said, "Yes the amount of people and being in a crowd (made them feel safe)". A relative told us, "I have absolutely no concerns that [person's name] is safe".

Staff knew how to keep people safe and to protect them from avoidable harm. One staff member told us, "If someone has a fall we do a body check for any sign of injury. We then put observations in place or phone out of hours. We fill out an accident report". Staff were able to describe different types of abuse and knew how to report any concerns either to the registered manager or to the local authority. This was in-line with the provider's policy on safeguarding adults. Staff told us, and records confirmed, that they had attended training to protect adults from harm and abuse.

We found that there was a call bell system in place for people to use. However, in some cases the call bell cord had been replaced to enable a sensor mat to be connected. A sensor mat tells staff when people get out of bed so that staff can then offer assistance to people who may require supervision to keep them safe. However, people who could use a pull cord to seek help did not always have one available. We spoke to the registered manager about this who said that they would immediately look into this to make sure that people could summon help from their bedrooms when this was needed.

Risks to people had been assessed and documented which meant that staff had information on how to protect people from possible harm. For example, a person required a hoist to transfer them, from one position to another. The risk assessment considered how to reduce the likelihood of harm to the person. We saw that other assessments focused on what people could do or needed support with and were regularly reviewed.

Where people could have become anxious and needed support to keep themselves and others safe, a staff member told us about their approach, "I talk to them and explain what's happening. It sometimes works. Sometimes they are really adamant and I just sit with them". There were plans in place on how to support people in times of distress. For example, we saw records that documented the need to offer reassurances to a person. However, the information was limited and did not detail what might make the person anxious and how the person could have been supported to limit any distress. This meant that staff did not have complete guidelines on how to keep people safe. We spoke with the registered manager about this who said that they would review the information.

Relatives told us that they were satisfied with the environment, particularly their family members' bedrooms. One relative said, "The room is lovely, really nice. It is always clean, there are no odours. Another relative said, "There is a step which is difficult for some people but the staff are excellent to help to keep people safe". We saw that environmental risks to people had been considered. For example, radiators were covered and doors were locked where hazardous chemicals were stored.

We looked at how the provider had planned to keep people safe during an emergency and found that there were continuity plans in place for staff to support people during such an emergency. However, the information for some people was not current. For example, there was a person having a short-break at the home but there was no emergency plan to support the person to evacuate them safely if this was necessary. This meant that people were potentially at risk as staff did not have the correct information available to them. We spoke with the registered manager about this who told us they would update the records.

Where people had fallen, we saw that records indicated what action had been taken to prevent a similar incident occurring again. However, the records were not always accurate. For example, one fall was documented as witnessed but other records stated that the same fall was unwitnessed. We spoke to the registered manager about this who amended the records.

We checked to see if the premises and equipment were being checked to keep people safe. We found that equipment was being regularly checked and serviced but records did not always reflect this. For example, in the fire records we found that the fire service had identified actions for the provider to undertake. However, there was no means of recording any action and follow-up that had been undertaken. We spoke to the registered manager about this who told us that the action had been taken but had not been recorded. We also found that regular testing of the fire alarm system had not been documented. The registered manager advised us that tests had occurred and would make sure future tests were recorded. We found that the

Requires improvement

Is the service safe?

provider was checking the water for legionella but we could not find a risk assessment that detailed how the registered manager had planned to reduce the risk to people who lived at the home. We spoke to the registered manager about this who told us that they would arrange for a risk assessment to be carried out.

Relatives had mixed views about the staffing levels at the home. One relative told us, "The staff ratio at night might need looking at…it's quite low and what they have to do is quite a lot". Other relatives told us that they felt the staffing levels were adequate. Staff told us that there were enough in the daytime but thought that an additional staff member was needed during the night. This was because some people required a lot of support. On the day of our visit we found that staffing levels were appropriate to keep people safe. We spoke to the registered manager about how they had calculated the amount of staff required and they told us that they had not recently undertaken this but would carry this out.

The registered manager had undertaken recruitment in a safe way. We found that the appropriate checks on prospective staff had been carried out to make sure that they were suitable to work with people. On-going checks were in place to continually check the suitability of staff so that the registered manager was confident people were being supported safely.

People received their prescribed medicines in a safe way. We observed medicines being offered to people. The staff member offered pain-relieving medicine to a person and asked, "Would you like your pain relief"? We saw that the staff member gave the right medicines to people, made sure that medicines were never left unattended and took care to record the administration. A staff member told us, "We check out with each other if we're unsure about anyone's medicines". We looked at a range of records and we found that medicines that had been offered had been recorded thoroughly. In this way medicines were handled safely in line with the provider's policy and procedures.

Requires improvement

Is the service effective?

Our findings

At the last inspection on 10 November 2014 we asked the provider to take action to make improvements. We asked them to improve their practice on gaining people's consent and to follow the requirements of the Mental Capacity Act (MCA) 2005. Following that inspection the provider sent us an action plan detailing what action they were going to take.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in the person's best interest and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA. We found that only minor improvements had been made since our last inspection. We still had concerns that the MCA was not being followed in relation to obtaining people's consent and acting in accordance with it.

We saw that many of the people living in the home had difficulty making decisions, for example, we saw that four people could not make a decision about their choice of food. We looked at how the registered manager had assessed people's capacity to make such decisions for themselves. For two people capacity assessments had been completed but these were not specific to a range of decisions nor had they been reviewed. We observed that both of these people would have lacked the capacity to make specific decisions. There were no references to a best interest's decision having been made by people involved in the person's care. We spoke to the registered manager about this who told us that in one case a healthcare professional had made a decision on a person's behalf. This meant that there was a risk that people were receiving care that had not been fully considered in line with the legislation of the MCA.

We saw records that confirmed one person had been resistive to personal care support. However, there was no mental capacity assessment in place detailing if the person understood the need to maintain their hygiene or plan in place for staff to support the person. We also saw that this person used a recliner chair for long periods in the daytime. Records showed that this person slept in the recliner chair at night. This could have constituted restraint under MCA legislation.

Staff told us, and records confirmed, that staff had received training on the MCA and DoLS. However, when speaking with staff they did not show an understanding of what restraint might include. For example, staff told us that restraint was not used in the home. However, we found that bed rails, sensor mats and recliner chairs were all in use and could constitute restraint. This meant that staff were not fully aware of what restraint meant under current laws and people were at risk from unsafe and illegal practice. There was a lack of consistency among staff members in their understanding of how capacity assessments and best interest decisions were used in the service. This meant that the provider had not made sure that the staff had fully understood the MCA and people were at risk of their human rights not being protected.

We saw records that showed the registered manager had made several DoLS applications to the 'supervisory body' (the local authority) for authority to restrict people's freedom. However, staff told us that there were several people subject to a DoLS authorisation but the registered manager confirmed that only one had been approved. Where DoLS authorisations had been submitted, these were in relation to key pads on the doors and people needing constant supervision. The registered manager had not considered that other forms of restraint such as sensor mats, already in place in several people's rooms, might have required the need for a DoLS authorisation.

We saw that a statutory advocate had been involved for a person regarding their DoLS authorisation. This was an Independent Mental Capacity Advocate (IMCA) who had supported the person who had lacked capacity to make decisions for themselves. This meant that the person was getting support to make sure that decisions made on their behalf were in the person's best interests.

Records did not indicate if consent had been obtained for the care offered in three people's files. This meant that people may have been receiving care that had not been

Is the service effective?

consented to by themselves or a person who could legally make decisions on their behalf. However, we did see on a fourth person's file that decisions about the person's end of life wishes had been taken by a family member who had the legal right to do so.

These matters constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that they thought the staff team had the skills and knowledge to support their family members. One relative said, "They know how to care for [person's name]". Another relative told us, "Yes, they know what they're doing, the staff are knowledgeable". Staff told us there was enough training and they felt this was comprehensive.

We looked at the training records and found that staff had received regular training. For example, training had been undertaken in the moving and handling of people and emergency first aid. We also saw that condition-specific training had been undertaken including diabetes and dementia. The registered manager told us that future training plans included end of life care.

We saw that the lunchtime meal was unhurried, the food served was hot and people seemed happy with the food offered. One person commented to another, "I like the dinner". We observed how people with dementia were being offered choices. Some people looked confused when staff members were speaking with them. Staff members did not use any aids to communication such as pictures or objects which could have helped people with dementia to make choices. This meant that the training on dementia that the provider had arranged had not been effective in supporting people with this condition. We spoke with the registered manager about this who told us they would look at different ways to give people information when giving them a choice.

Staff had received support from the registered manager. A staff member told us, "On induction we looked at policies and procedures, shadowed for two weeks…To be honest it was useful, especially the shadowing as I used to work with children and this is a bit different". Records showed that new staff were completing the Care Certificate. This is an induction programme that aims to give new staff the knowledge and skills needed to work well with people they offer support to. Staff members told us that they felt supported and received supervision. Supervision is a process between a staff member and the registered manager to discuss progress and to receive guidance and support. Records confirmed that regular supervision was taking place. In this way, the registered manager had discussed with staff the effectiveness of care being offered to people.

People told us that they were satisfied with the food offered. One person said, "The food's nice, I enjoy it". Relatives were also complimentary about the food and drink. One relative told us, "I am amazed at the food, it is home cooked and healthy". We saw that people were supported to have enough to eat and drink.

Where people were at risk of malnutrition, regular assessments had been completed and records showed that the home had maintained people's weight. In this way, the registered manager was able to monitor any changes needed to a person's nutrition.

People were supported to maintain their health. A relative told us, "Their attention to calling the doctor when they feel it's relevant is excellent". Staff told us that GPs are called if a person became unwell and records confirmed this. We saw people had regular health appointments including visits from the chiropodist and the dentist. Daily notes detailed any changes to a person's health which meant that staff had up to date information available to them in order to support people effectively.

Requires improvement

Is the service caring?

Our findings

People told us that they thought the staff members were caring. One person told us, "I like the staff. They look after me well". Another person said, "Yes, they are kind to me". Relatives confirmed the caring approach from the staff team. One relative told us, "The staff are caring and they have got the right approach…there is no-one that doesn't care". Another relative said, "[Person's name] is treated with such compassion". We saw staff showing patience and giving time to people when required to complete tasks. For example, we saw that a staff member encouraged and offered assistance to a person to walk as far as they could. The staff member did this in a gentle and calm way offering the person their wheelchair when they became tired. We also saw a person being supported to move with equipment. The staff members explained what they were doing and encouraged the person to do as much for themselves as they could. In these instances, staff showed a caring approach.

We saw that when a person requested it staff did not always sit and talk with them about things that were important to them. One person was trying to engage in conversation with staff over a period of an hour with no meaningful response from staff members. Staff were largely focused on care tasks including making sure people had a drink. We spoke with the registered manager about people not always being supported in a caring way who told us they would speak to the staff team to remind them to spend time with people.

On occasion we heard staff members talking about people's needs and conditions in front of other people. This meant that people's privacy and dignity was not being maintained. On other occasions staff discreetly asked people if they required the toilet. Records contained information about people's life histories but this information was not being used to engage with people. We spoke with the registered manager about these issues who said they would talk to the staff team about upholding the dignity of people.

We found that bedrooms were personal and individual and focused on what was important to the person. There were dignity cards that were placed on people's doors when they were receiving personal care support. This meant that on these occasions people's dignity was being respected.

We saw that people's preferences had been detailed in people's care plans and were being respected. For example, one person's care plan made reference to them liking two pillows when they were in bed. We looked in this person's bedroom and found them to be in place. However, it was unclear if staff understood about people's specific preferences. For example, water was the only drink available at lunchtime and the meals were all served with gravy. There were no opportunities for people to help themselves or decide how much they wanted.

Where people were able to make decisions for themselves, they were not always involved in their own care and support. For example, drinks were given to people without staff members asking people what they preferred. Relatives had mixed views about if they had been involved in the planning of their family members' care and support. One relative told us, "We have been updated and once a year we are invited into the home for a meeting". Another relative said, "We have never been invited to a meeting". We saw that records did not show how people or significant others had been involved in the planning of their care or review of their needs. This meant that there was a risk that people were not receiving care of their own choosing. We spoke to the registered manager about this who told us that they would look at how they could improve involving people or significant others in the planning of their care.

We saw that confidential information about people was kept secure. We saw that staff were careful in the storage of information and made sure that cupboards were kept locked when they were unattended. This meant that information was not available to persons who should not have access to it.

Relatives told us that they could visit at any time during the day. Relatives generally avoided mealtimes as they recognised that these were busy times of the day. One relative told us, "They (staff) are always friendly and make us feel welcome". We saw that relatives visited on the day of our inspection.

Requires improvement

Is the service responsive?

Our findings

A relative told us that they had contributed to their family members' assessments prior to them living at the home. One relative said, "They came to do an assessment first with me and mum. Mum spoke for herself". "Another relative told us, "They are very good at keeping us up to date and I often give them information". Some people's care plans detailed their individual preferences showing that they had contributed to their care plan. For example, we saw that one person had specified their choice about the gender of staff offering them support. In other people's care plans it was not clear if they had contributed to the assessment and planning of their care. We spoke with the registered manager about this who told us that they would review their records.

We checked to see if staff members were offering support as indicated in people's care plans. We saw that one person needed support to be turned every two hours. We looked at the daily recording of this and found that the person was supported in this time frame. We also checked the food and drinks charts that were in place to make sure a person got the right amount. This was important as the person was at risk of losing weight. We found the records to be complete.

We saw that one person had a pureed meal. We asked a staff member the reasons for this. We were told that the person's daughter wanted the person to have a solid diet but that staff did not have the time to assist with this and that there was a risk of choking. We looked at this person's records and found that there was no information on the person requiring a soft diet or any difficulties the person had with solid food. There was no record of any input for a dietician or speech therapist. We looked at another person's records and we found that the person was having a soft diet. There were no recorded reasons for this or input from healthcare professionals. We also found that the records did not indicate if the two people had been involved in decisions about how their food was offered. We spoke to the registered manager about this who told us that they would review the care plans.

We saw that care plans were updated monthly but did not pick up on information that was incorrect. For example, one person's mobility care plan contained discrepancies about the equipment they needed to assist them. We spoke to the registered manager about this who told us they would review the information. We spoke with staff about how they knew about people's preferences and support needs. Staff told us they referred to people's care plans.

We saw that the service had made some considerations about needs of people who had dementia. For example, there were photographs on people's bedroom doors to help them to identify their rooms. We also saw that bathrooms were identified with pictures to assist people to recognise where these rooms were. There were activity boxes designed to generate discussions with people about their past but these were not being used when we visited.

People had mixed views about the activities on offer. One person said, "I do colouring, like this morning and I like knitting. I go out when it's fit, but not lately. Yes there's enough to do". Another person told us, "We play a bit of a game, we don't get out much. I could go out but I like to sit down. There's not many activities to be truthful". Relatives shared people's views. One relative said, "Activities tend to come in fits and starts, I had to prompt them to complete the activities board…they (activities) are not as structured as they could be". Another relative told us, "There are jigsaws and puzzles, I'm not sure what else there is". One staff member commented, "We do our best with activities. I'm not trained as an activities co-ordinator, but we do our best. We set their hair, have a memorabilia box, quizzes and sing along. I do some exercise to music".

On the day of our visit staff members had brought their dogs in for people to see which made people smile. The activity board showed that this was planned. However, in the afternoon the planned activity was singing but this did not occur. We saw that some people were sat for long periods of time without being asked if they wanted to undertake an activity. The television was on but people showed little interest in it. We spoke to the registered manager about the activities offered to people who told us they would look to review these.

We saw records that detailed the things people were interested in and these were sometimes in place. For example, a person was cared for in bed and liked to listen to the radio which was on when we visited the person in their room. We asked staff about how they had responded to people's cultural or religious needs. The staff members we spoke with were not aware that people had these. A relative confirmed to us that their family member liked to see the vicar which sometimes occurred. This meant that

Requires improvement

Is the service responsive?

staff did not understand that this constituted a religious need for a person. We spoke to the registered manager about this who said that they would speak with staff members about people's cultural and religious needs.

We observed the handover of information when staff came on duty. The senior member of staff discussed aspects of people's well-being such as having their hair done, activities undertaken in the morning, their mood and general demeanour. Information about people's sleep, eating and drinking and health was also handed over. This meant that staff had up to date information on people's care needs and so could offer responsive support to people.

People told us they that felt listened to. If they wanted to raise a concern, one person gave us the name of a carer they would speak with and one person said their family. Relatives confirmed that they knew how to make a complaint and that they would speak to the registered manager in the first instance. One relative told us, "Mum complained that she had not had enough to eat but they acted on it straight away". Staff told us about how they would deal with a complaint by taking it to the registered manager. We saw that the complaints procedure was displayed so that people and relatives knew how to raise a complaint. We saw that the provider had received two complaints in the last year. In both cases the registered manager had taken action to address the issues in line with the provider's complaints procedure.

We saw that regular residents meetings had occurred. The registered manager explained that relatives had been invited but often did not attend. People had been able to offer suggestions for improvements and had been invited to give feedback on the service. We saw that people had been asked about their views on staff members' approach and ideas for activities. A relative confirmed that the provider did seek feedback from people and told us, "They do ask people if they're happy which is good". The registered manager had implemented 'Residents' listening forms' for everyone who used the service. These asked people on a monthly basis for feedback on, for example, their general well-being, diet and activities on offer. This meant that people were regularly able to share their views and concerns.

Requires improvement

Is the service well-led?

Our findings

At the last inspection on 10 November 2014 we asked the provider to take action to make improvements. We found that there was an absence of effective procedures for monitoring and assessing the service. We asked them to improve practice relating to having effective procedures in place for regularly assessing the quality of services provided. The provider sent us an action plan to tell us how they would make the improvements. At this visit we found that the provider had made progress towards having effective quality checks in place but these required improvement.

We asked the registered manager about how they had checked the quality of the service. We were shown a range of quality audits that had been regularly completed. These included the checking of people's bedrooms, monitoring charts that were in place for people, cleaning records and call bells. We found that they were not effective in identifying issues that had been found on the day of our inspection. For example, call bells were found to be working and accessible in the audit but we saw that for some people they were not in place. We saw that most of the audits did not show an analysis of the information gathered and there was no recording of any follow-up action required. For example, we saw that people's walking frames were not always in easy reach of people but the audit of this showed consistently that they were. This meant that although quality checks were in place they were not effective in delivering high quality care. We spoke to the registered manager about this who told us that they would consider our feedback.

People spoke positively about the registered manager. One person told us, "I like her". We asked relatives about the registered manager. One relative said, "The manager is approachable and to the point. I like her approach". The four staff members that we spoke with told us that the manager was approachable. One staff member said, "I love the manager, she's like family…can be stern with us if we do something not to her standards but you can speak to her about anything". Staff also confirmed that they felt supported by the registered manager. We saw records that showed us that the registered manager was fair in their approach to staff. For example, we found that a recent concern from the local authority had been addressed by the registered manager with the staff members involved in line with the provider's disciplinary policy.

We spoke to staff about how they would raise a concern about other members of the team. Staff told us that they would discuss this with the registered manager and one staff member told us that they could contact the CQC. This was in line with the provider's whistle-blowing policy that was on display. In this way staff had clear information and guidance on reporting concerns.

We saw that the provider's Statement of Purpose was displayed which outlined what people could expect from the service. We spoke to the registered manager and staff members about this who shared a common vision that the service should provide excellent care and support to people. We saw that healthcare professionals had given feedback to the home about the positive approach by staff members in maintaining a person's independence. In this way the staff team strove to offer a high quality service.

We asked relatives if they had been asked to give feedback to the provider. Relatives had mixed views on this. One relative told us, "I've done two questionnaires that I've been given, but no, I haven't been given the results". Another relative said, "There has been no feedback asked for". We could also not see how feedback forms completed with people had been followed up. We asked the registered manager about providing people and relatives with the results of any questionnaires given out and were told that this had not occurred. This meant that people and their family members were not aware of how the registered manager had planned to make changes based on the feedback received. We spoke with the registered manager about this who told us that this had not happened but would look at doing this when questionnaires were sent out again.

The registered manager was established in their post and we saw examples of good leadership. On the day of our visit the registered manager was available to staff members to offer advice and support to enable quality care to be delivered. For example, the registered manager worked with a staff member to understand and support a person's changing needs. We also saw that regular staff meetings had occurred that covered topics such as reminders for staff to maintain people's privacy and to check regularly about the stock of medicines. A staff member told us that

Requires improvement

Is the service well-led?

they could make suggestions for improvement. For example, we were told by one staff member that they had discussed the need for additional staffing with the registered manager who was open to the discussion.

It is a requirement that the registered manager informs the CQC of significant incidents or alerts of actual or possible harm or abuse. We found that the registered manager had acted appropriately to do this.

The registered manager told us that they had been receiving ongoing support from the local authority's quality improvement team to make improvements to the service. Visits had been regular and the registered manager was open to receiving suggestions on delivering high quality care. In this way the registered manager acted in a way that was open and transparent to support the service to improve.

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People's consent to their care had not been fully considered and the provider had failed to act in accordance with the MCA 2005. Staff were not familiar with the MCA 2005. Regulation 11 (1) (3).