Lifestyle Care Management Ltd

Knights Court Nursing Home

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**

Summary of findings

Overall summary

This unannounced inspection took place on 26 and 27 July 2016 and 1 August 2016.

Knights Court Nursing Home provides accommodation and nursing care for up to 80 older people, some of whom may also have dementia. There were 63 people living at the home when we visited.

At our last inspection on 14 July 2014 the service met the regulations inspected.

There was a registered manager in post at the time of our inspection. 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.

People told us they felt safe living at the home. Relatives told us that they were confident people were safe living in the home.

However, we found that some practices within the home left people at risk of unsafe care and support. In the six months prior to our inspection, a number of people had acquired pressure sores that were rated as grade three or four, which meant they were at high risk of developing life-threatening infections. During our visit we reviewed people's care and support records looking at how pressure area risks were identified and managed for people. We saw that there was a lack of consistent documentation in respect of turning and repositioning of people. We found a breach in respect of this.

There were some systems and processes were in place to help protect people from the risk of harm and staff demonstrated that they were aware of these. Staff had received training in safeguarding adults and knew how to recognise and report any concerns or allegations of abuse.

Risk assessments had been carried out and staff were aware of potential risks to people and how to protect people from harm. People's care needs and potential risks to them were assessed. Staff prepared appropriate care plans to ensure that that people received safe and appropriate care. People had access to healthcare professionals.

On the day of the inspection we observed that there were sufficient numbers of staff to meet people's individual care needs. Staff did not appear to be rushed. However some people who used the service and the majority of relatives we spoke with told us that staffing levels were inadequate at weekends. This was confirmed by staff we spoke with. We raised this with management and they informed us that staffing levels were regularly reviewed depending on people's needs and occupancy levels. They acknowledged that on weekends there were occasions when there were staff shortages because of staff sickness and difficulties finding cover. The registered manager told us that they continuously review the staffing levels at weekends.

Systems were in place to make sure people received their medicines safely. Arrangements were in place for the recording of medicines received into the home and for their storage, administration and disposal.

Staff employed by the service underwent a robust procedure to check they were appropriate people to work with people. Staff had been carefully recruited and provided with induction and training to enable them to care effectively for people. They had the necessary support, supervision and appraisals from management.

People's health and social care needs had been appropriately assessed. Care plans were person-centred and specific to each person and their needs. Care preferences were documented and staff we spoke with were aware of people's likes and dislikes. People told us that they received care, support and treatment when they required it. Care plans were reviewed monthly and were updated when people's needs changed.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA 2005). Capacity to make specific decisions was recorded in people's care plans.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensure that an individual being deprived of their liberty is monitored and the reasons why they are being restricted is regularly reviewed to make sure it is still in the person's best interests. The home had made necessary applications for DoLS and we saw evidence that authorisations had been granted and some were awaiting approval.

There were suitable arrangements for the provision of food to ensure that people's dietary needs were met. There were mixed reviews about the food provided. Details of special diets people required either as a result of a clinical need or a cultural preference were clearly documented.

We observed lunch being served in the lounge on each of the four units in the home. People sat with other people however we found the atmosphere dull as there was a lack of interaction from staff. Staff tended to be more task focused and did not sit and interact with people to ensure lunchtime was an enjoyable and sociable experience. They talked with one another rather than with people using the service. We discussed this with the registered manager who told us she would review the arrangements for mealtimes to ensure the atmosphere was improved.

Throughout the days of our inspection we observed that people were treated with kindness and compassion. The atmosphere in the home was calm and relaxed. People were treated with respect and dignity.

People and relatives spoke positively about the atmosphere in the home. Bedrooms had been personalised with people's belongings to assist people to feel at home.

There were mixed reviews about activities available in the home. During our inspection we saw limited evidence of activities taking place. We also observed that activities that people participated in had not been recorded consistently since May 2016 and therefore it was not evident whether people had taken part in activities. We have made a recommendation in respect of activities available in the home.

Staff were informed of changes occurring within the home through daily staff meetings as well as general staff meetings. Staff told us that they received up to date information and had an opportunity to share good practice and any concerns they had at these meetings.

The home had carried out satisfaction surveys prior to resident and relative meetings. This enabled

management to discuss people's feedback at the meeting. We noted that the last survey had been carried out in May 2016.

There was a management structure in place with a team of nurses, care workers, kitchen and domestic staff, clinical lead, deputy manager and the registered manager. Staff told us that the morale within the home was good and that staff worked well with one another. Staff spoke positively about the registered manager and the support received from her. They said that they did not hesitate about bringing any concerns to the registered manager.

There was a quality assurance policy which provided information on the systems in place for the provider to obtain feedback about the care provided at the home. The service undertook checks and audits of the quality of the service and took action to improve the service as a result. However, there were some areas where the quality of the service people received was not effectively checked and the service failed to identify these failings.

Relatives spoke positively about the registered manager. They said that the registered manager was approachable and willing to listen. Complaints had been appropriately responded to in accordance with the service policy.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. We found that people at risk of acquiring pressure sores were monitored however we found that documentation in respect of checks were not consistent.

People who used the service and relatives we spoke with said that they were confident the home was safe.

Staff were aware of different types of abuse and what steps they would take to protect people. Risks to people were identified and managed so that people were safe and their freedom supported and protected.

We saw that appropriate arrangements were in place in relation to the management and administration of medicines.

Staff underwent a series of checks before starting work to help ensure they were appropriate for their roles.

Is the service effective?

Requires Improvement

The service was not always effective. Whilst people's nutrition and fluid intake was monitored, there was a lack of evidence that this was always documented clearly in people's care records.

The atmosphere during lunch was dull as there was a lack of interaction from staff. Staff tended to be more task focused.

People were provided with choices of food and drink.

Staff had completed training to enable them to care for people effectively. Staff were supervised and felt well supported by the registered manager.

People were able to make their own choices and decisions. Staff and the registered manager were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the implications for people living in the home.

Is the service caring?

Good

The service was caring. People were treated with kindness and compassion. The atmosphere in the home was calm and relaxed.

People were treated with respect and dignity. Staff respected people's privacy and dignity and we observed this during the inspection.

Wherever possible, people were involved in making decisions about their care. Care plans provided details about people's needs and preferences. Staff had a good understanding of people's care and support needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were a lack of activities available for people to participate in at the home. We have made a recommendation in respect of this.

Care plans were person-centred, detailed and specific to each person's individual needs. People's care preferences were noted in the care plans.

The service carried out a formal satisfaction survey in order to obtain feedback from people who used the service and relatives.

The home had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led. Checks and audits had been undertaken. However some of these carried out were not effective at highlighting deficiencies in the care provided.

People and relatives told us that the registered manager was approachable and they were able to raise concerns with her if they needed to.

Staff were supported by the registered manager and told us they felt able to have open and transparent discussions with her.

Knights Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 27 July 2016 and 1 August 2016 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector, a specialist advisor who was a tissue viability nurse, and an expert by experience. 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 the inspection we reviewed information we had about the service in our records. This included information about safeguarding alerts, notifications of important events at the service and information from members of the public. We also spoke with an officer from the local authority safeguarding adults team.

The provider also completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR also provides data about the organisation and service.

During our visit we spoke with 11 people who use the service and 11 relatives. We observed care and support to people and 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 spoke with 16 members of staff which included six care workers, four nurses, management and domestic staff. We also spoke with five care professionals who had contact with the home.

We looked at ten people's care and support records and seven staff personnel files. We looked at other

records related to the management of the service such as records of audits and checks, complaints, meeting minutes, maintenance records and health and safety records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "Yes, I am safe here." Another person nodded and said, "Yes." when asked if they were safe in the home. Relatives told us that they were confident people were safe. One relative told us, "[My relative] is in safe hands." Another relative said, "I am confident that [my relative] is safe here."

However, we found that some practices within the home left people at risk of unsafe care and support. In the six months prior to our inspection, a number of people had acquired pressure sores that were rated as grade three or four, which meant they were at high risk of developing life-threatening infections. At the time of our inspection there were seven people in the home with a grade three or four pressure sore. During our visit we reviewed people's care and support records looking at how pressure area risks were identified and managed for people. We saw that there was a lack of consistent documentation in respect of turning and repositioning of people. Records we viewed showed that staff identified areas of people's skin at risk of developing pressure sores but did complete documentation consistently. For example, in one person's care records we saw that the tissue viability nurse found on 9 June 2016 that the person had a grade three or grade four pressure ulcer on their right heel. However we found that there was inconsistent documentation of turning at night following this date. We also found that the root cause analysis report dated 1 June 2016 included a wound assessment but there was no evidence of wound measurements. We also noted that in one person's care records it detailed that they were to be repositioned every two hours. However we saw that for the 24 July 2016 there was no entry from 20:00-08:00am. The records indicated that this person had therefore not been repositioned during this period. However we noted that this person's pressure sore had improved and was healing. We discussed this with the registered manager and she explained that the repositioning had been carried out but that the records had not been updated. The registered manager told us that she would carry out an internal investigation as to why the records were not up to date.

The home used "comfort round charts". These were charts which recorded hourly or two hourly checks of people which included their position, pain, nutrition and toileting. The registered manager explained that these were to be completed in addition to repositioning and fluid charts and the aim of these was that they were a counter check to other checks carried out. However, we found that these were not consistently completed. For example, for one person we noted that the comfort round chart had not been completed fully on 22, 24 and 26 July 2016.

We found that the home was not consistently maintaining accurate, complete and contemporaneous records in respect of people's care. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a healthcare professional who specialised in tissue viability nursing care and who had worked with the home. They informed us that the registered manager was proactive in reporting pressure sores to them and the home took necessary action once a pressure sore had been identified. This healthcare professional explained that they had seen evidence of people's pressure sores healing and said that the concerns they had were around the records and the home not consistently recording when turns were being

carried out. They did not feel that the home was acting negligent in respect of pressure sores but said that they needed to improve their records.

We also spoke with a medical professional who visited the home on a regular basis. The person said that the nursing care was excellent in the home. They explained that the reason why there were a number of people with pressure sores in the home was because they were very ill with complex needs. This person explained that they did not feel that there was a safeguarding issue in respect of pressure sores in the home and said that they were confident that the home were not acting negligently in respect of pressure sore care.

We also looked at the efficiency of pressure relieving mattresses at the home. Pressure relieving mattresses are designed to reduce the chance of pressure sores for those people who are bed ridden. During the inspection we noted that mattress pumps were place on the floor, instead of being attached to the foot board of the bed. We raised this with the registered manager and she confirmed that this would be dealt with immediately. We also found inconsistencies in relation to pressure relieving mattresses and the mattress pump weight against people's weight. Pressure relieving mattresses are set at particular levels for each person depending on their individual weight. The registered manager explained to us that in each person's room there was a sticker at the foot of the bed detailing the person's name, weight and at what level the pressure mattress should be set depending on the person's weight. We looked at eight people's pressure mattress settings and found that there were some inconsistencies. For example, in one room we noted that the sticker stated the pump setting should be at 4-6 but the pump weight setting was at 9. We spoke with the registered manager about this and found that the sticker in this person's room was for another person. The person in the room was at a weight of 87.75kgs and therefore their setting should have been 6-7. The setting of 9 indicated that this was too high for the patient's weight. In another person's room the mattress pump was set to 6 to 7, however the sticker on the pump stated that the pump should be set at 3 to 4. In another person's room we found that there was not a sticker in the room detailing the person's weight and the setting at which the pump should be.

It was therefore evident that the pressure mattress settings were not always set at the correct level and were therefore not being managed effectively by the service. We discussed this with the registered manager and questioned why daily checks by staff had not identified these inconsistencies. The registered manager explained that staff carried out daily checks for each individual and this included checking the pressure relieving mattress settings. However we found that these checks were failing to identify these inconsistencies.

The service was failing to assess, monitor and mitigate the risks relating to people's health as they were not monitoring people's pressure mattress settings effectively. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager explained to us that she recognised that staff required further training around tissue viability and pressure sore care. She explained that nurses were going to receive refresher training in this area and this took place following the inspection on 28 July 2016. She also confirmed that the training was going to be provided to all care staff as a result of the number of people in the home with pressure sores. This training had been scheduled for 22 August 2016.

People's care needs had been assessed. Care plans we reviewed included relevant risk assessments, such as the Malnutrition Universal Screening Tool (MUST) risk assessment, used to assess people with a history of weight loss or poor appetite. Pressure ulcer risk assessments included the use of the Waterlow scoring tool and falls risk assessment. The service had identified individual risks to people and put actions in place to reduce the risks. These included preventative actions that needed to be taken to minimise risks as well as

measures for staff on how to support people safely. Risk assessments were reviewed monthly and we saw documented evidence that these were updated when there was a change in a person's condition.

On the first day of our inspection we noted that the front door to the home was open throughout the day and there was an occasion where no staff were present when a member of our inspection team arrived at the home. Some relatives we spoke with also commented on this lapse of security. We discussed this with the registered manager and explained that there was a risk that anyone could enter the home without the knowledge of staff. The registered manager acknowledged this and explained that the majority of the time there was a member of staff by the front door and the reason they left the door open was for fresh air to circulate in the home. However she confirmed that in future the door would be shut and locked and that they already had an electronic lock in place.

We looked at the staff rota and discussed staffing levels with the registered manager and staff. On the first day of inspection the staffing levels during the day consisted of the registered manager, deputy manager, domestic and kitchen staff, four nurses and 14 care staff. The rota indicated that there were eight care staff and two nurses on waking duty during the night. With the exception of two staff, staff we spoke with told us that there was generally sufficient staff for them to attend to their duties. However all staff said that during weekends there was occasions where there was a shortage of staff when people called in sick and were unable to work. Staff explained that it was difficult to provide cover at short notice.

When speaking with people who used the service we received mixed reviews about staffing levels. When asked about staffing levels, one person told us, "I've never felt there's a problem. There seem to be plenty of staff around, but I am able bodied." However, another person who used the service said, "I think they're understaffed. There used to be four carers at any one time, and now there tend to be three; it puts a strain on the system if one is absent or on leave. If I had the power, I would increase the staff a bit to have four at a time."

The majority of relatives we spoke with raised concerns about the number of staff on duty particularly on weekends. One relative told us, "There is a lack of staff on weekends. I cannot fault staff but there are not enough." Another relative said, "Today the staffing numbers are excellent. However on the weekends there is a lack of staff." Another relative told us, "They could do with more staff. Mainly on the weekends but they tell me that they are at full capacity of staff." Another relative explained to us that they had been on one unit that morning where there were six to eight people in the lounge and at one point there were no members of staff in the lounge. This relative explained that some people were capable of standing up and in danger of falling.

People who used the service and relatives spoke positively about the consistency of staff at the home. One relative told us, "There is stable staff. Not agency. It is excellent. Staff know people very well."

We spoke with the registered manager about the concerns raised about staffing levels and asked how the home determined how many staff they required on each unit. The registered manager showed us the dependency tool they used in order to decide this. We noted that this tool detailed each person's care needs and gave each person a score in order to decide how many staff were required. We also looked at staffing levels specifically on weekends from 19 June 2016 and noted that records indicated that there were two days out of twelve days where there was a shortage of staff at weekends. The registered manager explained that they would continuously review staffing numbers for the weekend.

The service operated robust recruitment procedures and checked that each staff member was a suitable person before they started work. Staff personnel records contained an application form detailing the staff

member's employment history in health and social care, criminal record checks and at least two written references.

Staff had been trained in safeguarding adults procedures and knew what to do if they had concerns a person was being abused. Care workers and nurses knew about the different types of abuse, told us they would immediately report any concerns, and knew to contact the local safeguarding authority if necessary. Our records showed that the service had responded appropriately to allegations of abuse and cooperated with local authority investigations.

The service had a whistleblowing policy and contact numbers to report issues were available. Staff were familiar with the whistleblowing procedure and were confident about raising concerns about any poor practices witnessed.

There was a record of essential maintenance carried out. These included safety inspections of the portable appliances, lifts, gas boiler and electrical installations. We noted that hoists were inspected by specialists on 21 July 2016 and they had found that two hoists were in a poor condition. We raised this with the registered manager and she explained that both had been removed and were no longer in use. She said that one had already been replaced and was in use and they were waiting for the other hoist to arrive.

There was a fire risk assessment dated March 2016 and we found that some deficiencies had been identified. We spoke with the registered manager about this and she confirmed that these had now been actioned and that there was nothing outstanding and showed us evidence of this. Personal emergency and evacuation plans (PEEP) had been prepared for all people.

Checks of the hot water temperature had been carried out regularly by staff. There were instructions in the bathroom for staff to check water temperatures prior to giving baths to people.

On the days of our inspection, the home was clean. Each person's room was cleaned daily and we noted there were no unpleasant odours. There was an infection control policy and measures were in place for infection prevention and control. We noted that staff had access to protective clothing including disposable gloves and aprons. We visited the laundry room and discussed the laundering of soiled linen with laundry staff. They were aware of the arrangements for soiled and infected linen and the need to transport these in colour coded bags and wash them in a sufficiently high temperature.

We checked six people's bedrooms and noted that in three of them the call bells were not within reach. We discussed this with the registered manager and she explained that they would review this. She also explained that some people were unable to use a call bell and a note was placed in those people's room detailing this and that they were checked hourly or two hourly by staff. We pressed the call bell twice during our inspection and staff attended promptly.
At this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies for twelve people who used the service. All prescribed medicines were available at the home. All medicines were stored securely in locked medicines trolleys (within locked treatment rooms). Staff secured the medicines trolleys to the walls of the treatment rooms when they were not in use.

The rooms where medicines were stored were clean with hand-washing facilities available. There were controlled drugs (CD) cabinets attached to the walls of the treatment rooms that complied with the Misuse of Drugs Regulation 1971. We checked the CD registers and they were satisfactory. Nurses checked the CDs at each shift change (twice a day).

Staff recorded the current, minimum and maximum fridge temperatures daily. We saw that medicines requiring refrigeration were stored at the correct temperatures to remain effective; however, it was not clear if the fridge thermometer was being reset correctly. Whilst the registered manager told us that nurses had been trained in how to use the fridge, we advised that training should be sought again.

Nurses monitored the temperatures of the treatment rooms. The readings provided assurance that medicines were stored at the correct temperature to remain effective.

A community pharmacy supplied medicines to the service on a monthly basis. Most tablets and capsules were dispensed into a monthly monitored dosage system. Staff had a checking process that involved two nurses to ensure that the correct medicines were delivered each month.

Staff kept records of stock levels of all medicines on the MAR charts and this was checked regularly. Staff wrote the "date of opening" on all medicines. Staff disposed of unwanted medicines via a waste contractor and kept records of this. Sharps were disposed of into a sharps bin, which was also taken away by a waste contractor.

Nurses were responsible for administering medicines to people and used a "non-touch technique" when doing so. We saw that "do not disturb tabards" were worn during medicines administration. When nurses gave medicines to people, they explained what they were doing and offered the residents water.

MAR charts were used to record the administration of medicines and creams. We looked at twelve MAR charts during this inspection. The MAR charts were computer generated by the pharmacy that supplied the medicines. A recent picture of each person was stored with each MAR chart. This assisted staff in identifying the correct person.

Staff documented allergy statuses for each person. There were no missed doses seen on the MAR charts. This provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed.

The MAR charts included information on how people liked their medicines to be administered. This included if the tablets were to be crushed. We saw evidence that the GP and pharmacist had been involved in the decision to alter medicines formulations.

Where a variable dose of a medicine had been prescribed (e.g. one or two tablets), staff recorded the actual number of dose units administered to the person.

Nurses used individualised topical MAR charts to record where topical preparations needed to be applied. Although healthcare assistants had received no formal training, they were supervised by nurses when applying creams and ointments and used the topical MAR charts to help them.

Nurses took responsibility for applying wound dressings to people and received training from a tissue viability nurse.

Staff could explain how to deal with people who needed their medicines to be administered covertly. (When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the resident.) The GP, a pharmacist and the next of kin of each resident were contacted before medicines were given covertly.

There was no self-administration of medicines at this home, however, there was a self-administration policy, and people were supported to self-administer if they expressed an interest in participating in this activity.

Although blood sugar levels were checked for people with diabetes, it was not clear if staff were correctly calibrating the blood glucose testing kit. This meant that staff could not provide assurance that the blood sugar readings were accurate.

A GP from a local practice provided medical cover to all the residents. The registered manager was present when the GP conducted the weekly visits. If medical assistance was required out of hours, staff dialled the NHS 111 service.

Nurses were able to access an online medicines training package on the safe handling of medication as part of their induction. They completed a calculations test, as well as a medicines competency assessment.

There was a homely remedies policy. Homely remedies are over the counter medicines that are available to people living in homes for the short-term management of minor ailments, for example, mild pain and coughs. Nurses were able to give medicines to residents using this policy for a set period. We saw that records were kept of this activity.

Nurses had protocols for the administration of medicines taken when 'as required'.

Nurses completed daily checks of the MAR charts to ensure that there were no gaps. The registered manager completed a monthly medicines audit as well as random spot checks. A pharmacist conducted a medicines audit every six months.

Staff knew how to report medicines incidents, and we saw that appropriate actions were taken after a medicines incident had occurred.

Requires Improvement

Is the service effective?

Our findings

People told us the care and support they received at the home was effective. One person said, "It's very comfortable. I'm very comfortably looked after." Another person told us, "They look after me well." Relatives told us that they were satisfied with the care in the home. One relative told us, "Care staff are effective. They know people well. They are friendly and accommodating." Another relative said, "This is a lovely home. Care staff are lovely and helpful." Another relative told us, "[My relative] seems happy. It's all ticking over nicely. They seem to do things properly. We're pleased she's here." One care professional we spoke with told us, "People come back to life here."

Care records showed that nutritional needs of the people who used the service were monitored. Where people had a low weight and a low body mass index, the service referred them to the dietician or GP for advice and were monitoring their progress. However, in one person's care plan it was evident that they had had a progressive weight loss which was recorded on 28 June 2016 but there was no documented evidence of dietician involvement. We raised this with the registered manager and she confirmed that the dietician had been notified and provided us documented evidence of this. We noted that this had not been recorded appropriately in the care records.

We saw that fluid and food charts were kept for people to record people's food and fluid intake. However we noted that these were not consistently recorded. For example, for one person we saw that the fluid and food form had not been completed on 24 July 2016.

The home was not consistently maintaining accurate, complete and contemporaneous records in respect of people's care. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had the knowledge and skills to enable them to support people effectively. We saw evidence that staff had undertaken an induction when they started working at the service. There was on-going training to ensure that staff had the skills and knowledge to effectively meet people's needs. Training records showed that staff had completed training in areas that helped them to meet people's needs. Topics included safeguarding, medicines, first aid, fire training, infection control and food safety. Staff spoke positively about the training they had received and were able to explain what they had covered during the training sessions. Some care support workers were in the process of completing the 'Care Certificate'. The new 'Care Certificate' award replaced the 'Common Induction Standards' in April 2015. The Care Certificate provides an identified set of standards that health and social care workers should adhere to in their work.

There was evidence that staff had received regular supervision sessions and this was confirmed by staff we spoke with. Supervision sessions enabled staff to discuss their personal development objectives and goals. We also saw evidence that staff had received an annual appraisal about their individual performance and had an opportunity to review their personal development and progress.

Staff spoke positively about the registered manager and told us that they felt supported by her. They

commented on the good team spirit amongst staff, good knowledge and skills possessed by staff in the home. One member of staff said, "I am very supported by the manager. I can go to her if I have any concerns. When speaking about the registered manager, one member of staff told us, "She is more than a manager. She is brilliant. She is always there for support." Another member of staff said, "The manager is great."

We looked at the arrangements in the home for food. There were mixed reviews about the food provided. One person said, "Food is good quality." Another person said, "The food is good, there is as much as you want. They are very accommodating." Another person told us, "I can have food I want. They cook my type of food." However another person told us, "The food's not very good, but the soup here is good."

During the inspection we spoke with the chef about the food prepared in the home. He was knowledgeable of people's dietary needs and preferences and told us that all the food prepared in the home was freshly prepared daily. The home had a weekly menu and it included a variety of different types of foods. There were alternatives for people to choose from if they did not want to eat what was on the menu.

During the inspection we observed people having their breakfast and lunch, which was unhurried. We observed meals on each of the four units. The atmosphere during breakfast and lunch was relaxed. Some people ate their meals in their bedrooms and some people ate in the dining area or lounge areas. People sat with other people however we found the atmosphere in units dull as there was a lack of interaction from staff. Staff tended to be more task focused and did not sit and interact with people to ensure lunchtime was an enjoyable and sociable experience. Instead they talked to one another rather than with people using the service. We discussed this with the registered manager who told us she would review the arrangements for mealtimes to ensure the atmosphere was improved.

On the first day of our inspection we observed that the menus on the tables in two units were for the wrong day (Monday, when it was Tuesday) and they were in plastic holders, some of which were broken and a bit grubby. We raised this with the registered manager and she confirmed immediate action would be taken.

The kitchen was clean and we noted that there were sufficient quantities of food available. We checked a sample of food stored in the kitchen and found that food was stored safely and was still within the expiry date. Food in packaging that had been opened was appropriately labelled with the date it was opened so that staff were able to ensure food was suitable for consumption.

A chart was displayed in the kitchen which showed each person's specific dietary needs and preferences. The head chef told us this was updated weekly or as people's needs changed. We noted that people requested specific meals that were not on the menu when they wished to.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We noted that care records contained mental capacity assessments including information about people's mental state and cognition. Staff had knowledge of the MCA and training records confirmed that the majority of staff had received training in this area. Staff were aware that when a person lacked the capacity to make a specific decision, people's families, staff and others including health and social care professionals would be involved in making a decision in the person's best interests.

We also found that, where people were unable to leave the home because they would not be safe leaving on their own, the home had made applications for the relevant authorisations called Deprivation of Liberty Safeguards (DoLS). We noted that the service had made necessary applications and some authorisations were in place and some were awaiting approval which the registered manager was fully aware of.

People had their healthcare needs closely monitored. Care records of people contained important information regarding medical conditions, behaviour and any allergies people may have. There was evidence of recent appointments with healthcare professionals such as people's dentist, optician and GP. Information following visits by GP and other professionals were documented in people's records.

People receiving end of life care had the appropriate plans in place. They also had "Do not attempt cardiopulmonary resuscitation" (DNACPR) forms in place. All the DNACPR forms we viewed were signed by the GP, relatives and nursing staff and were up to date. There were also care plans in place which clearly stated the end of life wishes for people.

Good

Is the service caring?

Our findings

People told us that they were well cared for in the home and that they were treated with respect. One person told us, "The staff are considerate." Another person said, "The carers are very caring, they have a sense of responsibility." Relatives told us that staff were caring in the home. One relative said, "Staff are very nice and patient. They go the extra mile." Another relative said, "Staff are very good. They are caring. Some are really dedicated to the job. They treat [my relative] very well." Another relative told us, "Staff are very friendly and caring. I have no doubt that they are caring."

Staff we spoke with had a good understanding of the importance of treating people as individuals and respecting their dignity. They also understood what privacy and dignity meant in relation to supporting people with personal care. We saw staff knocked on people's bedroom doors and waited for the person to respond before entering. Bedroom and bathroom doors were closed when staff supported people with their personal care needs.

When care staff were attending to people's care needs we observed respectful and caring interactions between care staff and people who used the service. Care staff showed interest in people and were present to ensure that people were alright and their needs attended to. Staff were attentive and talked in a gentle and pleasant manner to people. Care staff smiled and asked people how they were. People responded by either smiling or nodding. People appeared to feel comfortable and at ease in the presence of staff. The manner of staff when supporting people was respectful and compassionate. However care workers in some instances did not engage with people in a meaningful manner during mealtimes and we have addressed this under "effective".

We saw some detailed information in people's care plans about their life history and their interests. However we noted that this was not consistent in each file we looked at. We spoke with the registered manager about this and she explained that the service was in the process of transferring information from old format care plans into new format care plans. She explained that the new care plans would be completed fully with all the relevant information and a target date for this had been set for the end of September 2016. Staff were able to provide us with information regarding people's background, interests and needs. This ensured that staff were able to understand and interact with people.

People were supported to maintain relationships with family and friends. Relatives told us that they were well treated whenever they visited the home and they were kept informed about their family member's progress.

Care plans included information that showed people had been consulted about their individual needs including their spiritual and cultural needs. Each care plan included a cultural, spiritual and social values section. The registered manager explained to us that all people in the home are valued as individuals and treated with dignity and respect. She explained that the home supported people to continue practising their beliefs for example by helping them to access church ministers, local leaders or any other representation of their chosen culture or religion. The home had visits from local religious ministers weekly.

The home had a policy on ensuring equality and valuing diversity and staff had received training in ensuring equality and valuing diversity. They informed us that they knew that all people should be treated with respect and dignity regardless of their background and personal circumstances.

Kitchen staff informed us that they were fully aware of people's cultural meal requests and we saw that this information had been documented. Halal, Kosher and vegetarian meals were provided for some people who used the service.

People had free movement around the home and could choose where to sit and spend their recreational time. We saw people were able to spend time the way they wanted. Some people chose to spend time in the communal lounges and some people chose to spend time in their bedroom.

All bedrooms were for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Care plans were up to date and had been evaluated by staff and reviewed with people, their relatives and professionals involved. This provided staff with current guidance on meeting the needs of people. Staff we spoke with explained to us that they respected the choices people made regarding their daily routines.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us the service was responsive to their needs and they felt able to complain if they needed to. One relative told us, "They listen. I am totally able to complain without hesitation and they are responsive." Another relative said, "They listen to what [my relative] wants. The manager is very approachable and actually listens and does things." However one relative explained to us that their relative had not had hot water in their bedroom and a light in the bedroom had not worked for a significant period of time. This relative told us, "You give up in the end, no-one's listening."

There was a complaints policy which was displayed throughout the home. There were procedures for receiving, handling and responding to comments and complaints. We saw the policy also made reference to contacting the CQC if people felt their complaints had not been handled appropriately by the home. The service had a system for recording complaints and we observed that complaints had been dealt with appropriately in accordance with their policy.

There were mixed reviews about activities available in the home. One relative told us, "Yes there are activities here." However another relative said, "There are no activities; I saw them playing with a balloon today, I haven't seen that before. There used to be an activities co-ordinator and she would get a response from some of the residents." Another relative told us their relative used to go to cake-making classes at the home but he didn't know why the class had stopped. Another relative told us, "There used to be a list of monthly activities but I haven't seen one for a while, the one in the hall is out of date."

During our inspection we did not observe many activities taking place during the day. There was one activity on the first day of our inspection in the afternoon where some people were playing with a balloon. We did not see any further evidence of activities. We spoke with the registered manager about the lack of activities available in the home. The registered manager explained that since the activities coordinator had gone on leave indefinitely they had experienced difficulties ensuring that activities were available for people. She said that they were in the process of resolving this and had recently employed a new activities coordinator but were waiting for their employment checks before they were able to start working. We also observed that activities that people participated in had not been recorded consistently since May 2016 and therefore it was not evident whether people had taken part in activities. We also noted that the activities timetable in people's bedrooms were out of date.

We recommend that the provider reviews the provision of activities at the home to ensure people are provided with mentally stimulating activities.

Meetings were held for people living at the home as well as relatives where they could give their views on how the home was run. The home carried out satisfaction surveys prior to resident and relative meetings. This enabled management to discuss people's feedback at the meeting. We noted that the last survey had been carried out in May 2016. We saw the minutes from the last meeting which was held in May 2016. During this meeting people and relatives raised various issues with management and action to be taken was also recorded. People and relatives we spoke with confirmed that they could attend these meetings if they

wished to do so.

The service provided care which was individualised and person-centred. People and their representatives were involved in planning care and support provided. People's needs had been carefully assessed before they moved into the home. These assessments included information about a range of needs including health, social, care, mobility, medical, religious and communication needs. Care plans were prepared with the involvement of people and their representatives and were personalised. Staff had been given guidance on how to meet people's needs and when asked they demonstrated a good understanding of the needs of each person.

Care plans were reviewed monthly by staff and were updated when people's needs changed. The registered manager explained that the regular reviews enabled staff to keep up to date with people's changing needs and ensured that such information was communicated with all staff.

The registered manager explained to us that it was important to ensure that people felt able to raise their concerns and issues and had an opportunity to voice their opinion. People and relatives told us that they had confidence in the registered manager.

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about the registered manager and said that they had confidence in her. One person told us, "The manager listens and responds." Another person said, "The manageress is very approachable." Relatives told us that they were able to approach the registered manager if they had any queries. One relative told us, "The manager is excellent." Another relative said, "The manager has an open door. She is very good. I can always speak with her." Another relative told us, "The manager is nice and very open. She listens and is always joyful. She is always available."

We observed interaction between the registered manager and people who used the service and saw that people appeared comfortable around her and were able to engage in a conversation with her.

There was a management structure in place with a team of nurses, care workers, kitchen and domestic staff, the clinical lead, the deputy manager and the registered manager. We noted that the deputy manager and clinical lead had been in post for approximately three months. Prior to these appointments the registered manager was responsible for the day to day running of the home. During this inspection we found that the registered manager was still very much responsible for the day to day running of the home and that certain tasks had not been delegated to the clinical lead or deputy manager. We spoke with the registered manager about delegating some of these tasks to other members of the management team so as to reduce the burden on her.

There was a quality assurance policy which provided information on the systems in place for the provider to obtain feedback about the care provided at the home. The service undertook checks and audits of the quality of the service in order to improve the service as a result. We saw evidence that regular audits and checks had been carried at regular intervals in areas such as health and safety, equipment, cleanliness of the home, medicines and staff training. However, there were some areas where the quality of the service people received was not effectively checked and the service failed to identify failings. For example; the service had failed to identify the inconsistencies in the care documentation for those people who required repositioning or had pressure sores as referred to under the "safe" section of this report. Further, the service had failed to identify the inconsistencies highlighted with the pressure mattress settings.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding and health and safety. Staff were aware of these policies and procedures and followed them. People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

Accidents and incidents were recorded and analysed to prevent them reoccurring and to encourage staff and management to learn from these.

The service had a system for ensuring effective communication among staff and this was confirmed by staff we spoke with. Staff informed us that there were daily meetings where they could discuss the care of people and any specific issues on a daily basis. We also saw evidence that there were quarterly staff meetings where staff received up to date information and had an opportunity to share good practice and any other concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a). The service failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(2)(b). The service failed to maintain securely an accurate, complete and contemporaneous record in respect of service users. Regulation 17(2)(c).