Arden Park Care Limited

Arden Park

Inspection report

101 Armscott Road
Wyken
Coventry
West Midlands
CV2 3AQ

Tel: 02476635944

Date of inspection visit:
30 June 2016

Date of publication:
19 August 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**

Summary of findings

Overall summary

This inspection took place on 30 June 2016 and was unannounced. Arden Park provides care and accommodation for up to 31 older people. There were 30 people living at the home when we carried out our visit and this included one person who was in hospital. A number of people were living with dementia and had high physical care needs.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People had mixed views about whether they felt safe at the home. We observed at certain times of the day there was not enough staff on duty to keep people safe and meet their needs. Staff told us they would feel better supported by the provider if they had more staff.

Risk assessments were in place to minimise the risks to people's safety. However, risks were not always managed well and records did not always reflect identified risks. The registered manager and staff understood what constituted abuse and referrals to the local authority had been made when needed.

Medicines were not always managed safely and systems to check whether people received their medicines as prescribed were not effective.

The provider did not have sufficient systems and processes in place to assure themselves that people received a good quality service that met their needs. Audits and checks took place but there was no evidence that actions had been taken to improve the quality and safety of services provided to people.

People were referred to health professionals to ensure their health and well-being was maintained, but we identified that on an occasion there had been a delay before medical advice had been sought.

New staff received an induction and staff received training in health and social care. However, we observed staff did not always put their learning into practice to manage risks. Recruitment checks were carried out prior to staff starting work at the home to make sure they were suitable for employment.

Accidents and incidents had been recorded. However, this information had not been used to identify any patterns or trends, to help prevent them from happening again.

The registered manager and staff demonstrated knowledge of the Mental Capacity Act (2005) and DoLS and supported people if they lacked capacity to make their own decisions to ensure people were looked after in a way that did not inappropriately restrict their freedom.

People told us the staff were kind. However, we saw that not all staff respected people's right to privacy or spoke to people in a respectful way. People were encouraged to maintain relationships with people important to them and visitors were welcomed at the home.

People were satisfied with the food and drink provided and staff demonstrated good knowledge of people's dietary needs. However, the mealtime experience we observed was not positive for people.

Overall, individual staff members demonstrated a caring approach and knew the people they care for well. We observed people were not always offered choices and staff had limited time to spend with people. We saw 'task based' interactions between staff and people throughout our visit.

People's records contained insufficient information to ensure staff had the guidance they needed to meet people's needs. It was not clear how people had been involved in planning their care to ensure they received care and support that met their preferences, likes and dislikes.

People were satisfied with the social activities provided and had opportunities to pursue their hobbies and interests. The provider had made improvements to the environment to be more supportive of people living with dementia since our last visit. Plans were in in place to make further improvements.

People and their families were positive about the care provided and the running of the home. They told us they knew how to make a complaint.

We found three breaches of the Health and social care Act 2008 (Regulated activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

Most people told us they felt safe and staff had a good understanding of safeguarding procedures. However, staffing levels were not sufficient at certain times of the day and staff were not always available at the times people needed them. There were some procedures in place to protect people from the risk of harm. However, identified risks were not always accurately reflected or managed in a consistent way. The management of medicines meant people did not always receive their medicines and prescription creams as prescribed. Accidents and incidents had been recorded but were not analysed to identify any patterns or trends to help prevent them from happening again.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had undertaken training in order to meet people's needs, however they did not always put this into practice. Checks to ensure that staff had the skills and competence to provide care and support to people were not always effective. The registered manager and staff had knowledge of the Mental Capacity Act (2005) which supported people if they lacked capacity to make their own decisions. People were satisfied with the food and drink provided. Staff demonstrated good knowledge of people's dietary needs, however people's meal time experiences were not always positive. Support from health care professionals was mostly sought when needed to ensure people's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were caring and most individual staff members demonstrated a caring approach. People and their relatives were positive in their comments about the staff and the home and staff told us they wanted to provide good care to people. Staff promoted people's independence. However, people's right to privacy was not always respected and people's

dignity was not consistently maintained. People were not always involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support was not always responsive to people's individual needs. Care plans did not contain sufficient information about people's preferred routines. People were not consistently offered choices or were involved in planning their care. People had opportunities to follow their interests and to be involved in social activities. People knew how to make a complaint if they wished to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. Audits and checks were completed but these were not effective to benefit the people who lived there and drive improvement in the home. Staff told us they would feel better supported by the provider if they had more staff. People and the staff team had some opportunities to provide their feedback about the service provided.

Arden Park

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 30 June 2016 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience in dementia care. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

As part of our inspection we asked the provider to complete 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. Before the inspection we spoke to the local authority commissioning team who funded the care for a number of people. We asked if they had any information about the service.

We reviewed the information we held about the service and the statutory notifications that the registered manager had sent to us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

During the inspection we spoke to six people who lived at the home and four relatives. We also carried out a SOFI observation. SOFI is a 'Short Observational Framework for Inspection' tool that is used to capture the experiences of people who may not be able to tell us about the service they receive.

We spoke with seven staff including the registered manager, the provider's quality and compliance manager, care workers, the activities co-ordinator, and a kitchen assistant. We reviewed four people's care plans and daily records to see how their support was planned and delivered.

We reviewed records of checks that staff and the management team made to assure themselves people received a quality service.

Requires Improvement

Is the service safe?

Our findings

At our last visit in May 2014 we were concerned that the number of staff on duty in the afternoons was not consistent with the staffing tool used, and therefore staffing levels were not sufficient to provide safe care to the 29 people who were living at the home at that time. Following the inspection the provider confirmed staffing levels during the afternoon shift had been increased from three to four staff with immediate effect.

At the time of this inspection visit, 30 people lived at Arden Park, and an additional person was in hospital. Despite there being more people at the home than at the time of the previous inspection, the registered manager told us that the provider had decreased the number of staff so three care staff were on duty during the afternoon and early evening. Eleven people required assistance from two members of staff, which meant there was one member of staff available to observe people in the communal areas and respond to any other requests for assistance at this time. This included support for people who were living with dementia. This was not sufficient. We saw that staff were busy at this time and were task orientated, which meant they had little time to interact with people. For example, one person needed to use the toilet, but there were no staff available to take them and they became anxious. We asked where the staff were and were told one staff member was in the laundry and the other two were assisting people elsewhere within the home.

We observed staff tried to be responsive to people's needs. However, assistance was not always provided at the time people required because staff were not always available. For example, we saw one person was anxious. Their clothing was untidy and they requested help to tuck in their blouse. A member staff walked past and said, "I'll be with you in a minute." We saw this assistance had not been provided when we saw the person again an hour later.

Staff told us there were not enough of them to keep people safe and meet their needs. They told us several staff were leaving their employment at home in the next few weeks. They were particularly concerned because a number of people had high dependency care needs. One member of staff said, "To be honest we could do with an extra member of staff; some staff are leaving because of it." Another told us, "We have got a lot of residents who need two carers [to help them]. They are losing out on receiving our care because we are a member [of staff] down. In all honesty they [people] are not safe." They explained in the evening when they were helping people to get into bed there was one member of staff downstairs and this was not sufficient to keep people safe.

However, people thought there were enough staff to meet their needs. One person said, "I think there is enough staff usually. I ring my bell occasionally; they are pretty quick in answering it after a few minutes." Another told us, "I think there is enough staff. I don't ring my call bell very often, no need too; they come quite quickly when I do." Despite what people had told us we saw the number of staff on duty meant that staff were not always available at the times people needed them and care was task orientated. Staff had insufficient time to keep people safe.

This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about the staffing levels with the registered manager and the provider's quality compliance manager. The registered manager said, "There have been cutbacks [by the provider]. Staffing levels are usually sufficient but we would benefit from an extra member of staff on some days." They explained they used a dependency tool to determine how many staff were needed to provide safe support to people and they would immediately reassess people and then discuss with the provider how improvements could be made.

Medicines were not managed or administered safely. Clear guidance for staff was not available and effective audit procedures were not in place to ensure creams were applied according to people's prescriptions. Creams were stored in people's bedrooms and were accessible to people who lived with dementia, which presented a risk that they could be used in an unintended way . Creams were applied by staff, but the plans to ensure these were applied as prescribed were not sufficient. For example, one person's records had been handwritten stating cream should be applied twice a day to the person's legs but the name of the cream had not been recorded. We were concerned because at least five staff had signed the record to confirm application of the cream. The lack of information meant they could be applying the wrong cream. We were told by the registered manager how another person required their cream applied when their skin was sore and broken to maintain their health. Their records indicated their skin had been sore and broken in December 2015. However, records did not reflect that their cream had been applied at this time.

The dates of when creams were opened were not being consistently recorded. This presented a risk because after the expiry date, prescription creams may not be safe or they may lose their effectiveness. A series of regular checks and audits of people's medicines took place so if any errors were identified prompt action could be taken. However, the checks were not sufficient; because we saw some medicine administration records [MAR's] dated form over 12 months ago remained in people's bedrooms and had not been checked. The registered manager was the 'lead' for medicines management at the home and they acknowledged this practice was not safe and told us they would make immediate improvements.

Staff who administered medicines had received training and their competency had been assessed. This should have ensured they continued to manage medicines safely in line with good practice guidelines. However, we saw staff had not put this training into practice because pain-relieving medicine was not available for two people who needed it. The acting deputy manager explained this was because it had not been ordered from the pharmacy. The medicines should have been ordered five days in advance but this had not happened. The registered manager assured us the required medicines would be delivered later on in the day. They told us some staff who had handed in their notice had become 'sloppy' and were not undertaking all of their required duties. They acknowledged the provider's medicine policy had not been followed and they assured us they would take action to address our concern.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, people told us they were satisfied with the way they received their medicines. One person said, "Yes, I do, [get my medicine] it's twice a day, a regular amount." Another said, "I only take tablets three times a day, they [Staff] stay with me whilst I take them. They seem to be on time, it's hard to tell." A relative told us, "[Person] gets her medicine twice a day. I think they are on time."

We observed a medication round and reviewed four people's medicine administration records to check medicines were being managed safely. We saw staff followed good practice in relation to how they administered oral medicines. For example, they took medicines to people, provided them with a drink and watched them take their medicine, before returning to sign the MAR to confirm they had taken it. The staff

member locked the medicines trolley when they left it, so there was no risk medicines were accessible to people.

Risks associated with people's care had been assessed and were reviewed monthly. However, in some cases, where risks had been identified, people's care plans had not been updated. For example, we identified in some care plans, reviews had not taken into account changes in people's health as reflected in their daily records. Increased risk was not always identified so appropriate action was not planned for and taken to keep the person safe. For example, one person's daily records showed they had experienced a decline in their health over recent months, which had resulted in a loss of appetite, weakness and fainting. Their falls risk assessment had not identified the increased risk of this person falling due to their ill-health, and the plan to keep them safe had not been updated since August 2015.

We saw risks were not always managed safely by staff. For example, we observed staff assist a person to move from their wheelchair into a recliner chair using a sling and a hoist unsafely. The techniques staff used had put the person at unnecessary risk. The person was not positioned correctly in the sling and the sling started to slip which had potential to cause harm to the person and to staff. Staff alerted the registered manager who assisted the staff to prevent the person from slipping further. The registered manager agreed that the person has not been correctly positioned in their sling by the staff. This same person was seated in a recliner chair for most of the day. We saw they were continually slipping down the chair. On occasions we saw their legs were hanging off the end of the chair. This posed a risk that they could fall and staff had failed to identify this. We discussed this person's care with the registered manager who told us a referral to an Occupational Therapist for more suitable seating to ensure the person was safe had not been made.

The registered manager was the moving and handling trainer for the home. We discussed our observations with them and the provider's quality and compliance manager. They both acknowledged that staff had not demonstrated an understanding of risks involved and had showed lack of skill in supporting the person to move. They told us they would review the person's risk assessments and care plan immediately.

Procedures were in place to protect people from harm. For example, we saw the provider's safeguarding policy was on display in the foyer for people, their visitors and staff so they could report if they felt unsafe. Staff told us how to identify abuse and signs to look for which demonstrated their learning. One member of staff told us, "It can come in all shapes and forms such as financial, physical or sexual."

Staff understood their responsibilities to keep people safe from the risks of abuse. They told us they would report any concerns. One member of staff told us, "I would go straight to the manager. She would look into it and get the senior managers involved and if needs be, call the police." They explained if the registered manager did not take any action, they would ring the head office and tell a senior manager themselves or get in touch with CQC. Another member of staff said they felt confident to speak out if they witnessed any poor practice.

The registered manager told us they understood their responsibilities to protect people and to report potential safeguarding concerns. However, records showed us two safeguarding concerns which the local authority safeguarding team had been made aware of had not been correctly recorded. The registered manager assured us they had discussed both of the concerns with people's social workers but no records of these discussions had been kept. The quality compliance manager acknowledged that records of the discussions should have been kept. They told us they would immediately review the way incidents were reported to ensure if further safeguarding incidents occurred they were correctly documented.

The provider's recruitment procedures minimised the risk to people's safety. The registered manager told us

that new staff members were not able to start work at the home until recruitment checks had been completed, to confirm they were of good character and suitable to work with the people who lived at the home. Recruitment checks included references from previous employers and checks with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record.

The provider had taken measures to minimise the impact of unexpected events. The fire procedure was on display in a communal area of the home, which provided information for people and their visitors on what they should do in the event of a fire. Each person had a personal emergency evacuation plan, which detailed their individual needs to enable them to evacuate the building safely if required. Records showed fire alarms were tested each week, practice fire drills took place and staff received training in fire safety.

Records confirmed that accidents and incidents in the home had been recorded and copies had been sent to the provider, but it was not evident the records had been analysed to identify any patterns or trends to help prevent them from happening again.

Equipment used in the home was regularly checked, to ensure it was safe for people to use. For example, a hoist which was used to move people had been checked in March 2016 and we saw the next check was scheduled for September 2016. A maintenance team visited the home on a regular basis to undertake general repairs and maintenance checks of the building, to ensure it was safe.

Requires Improvement

Is the service effective?

Our findings

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 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).

The registered manager demonstrated they understood when they should apply to the Supervisory Body for the authority to deprive a person of their liberty. However, records for one person showed they had capacity to understand and weigh the risks and benefits of their decisions. The records stated, 'No diagnosed dementia or any other mental illness. Has a good understanding and is able to take in information, retain it and use it as a part of the decision making process.' Despite this assessment of the person's cognitive ability, an application for a DoLS had been submitted to the local authority for approval. We saw this request had been declined, on the basis that the person had capacity to make an informed decision. The registered manager acknowledged that this referral had not been required. They had misunderstood their responsibilities under the Act and they assured us this had helped them to develop their understanding.

Some people who lived at Arden Park lacked capacity to make their own choices. Staff we spoke with knew which people lacked capacity and understood why some decisions, needed to be made in their best interests. A member of staff told us, "We liaise with family members and get in touch with GPs and involve the deprivation of liberty services and the social worker." Another explained how they supported a person who did not have capacity. They said, "With [Person] we explain everything even though they cannot understand what we are saying." This demonstrated staff aimed to work in the best interests of people to ensure their needs were met.

People and their relatives told us staff had the skills and knowledge to care for them effectively. Comments included, "I think the staff do well, I think they do." And, "I think they are all trained well. We've no reason to think they are not."

Staff told us they received the training they needed to meet people's needs. A member of staff told us, "Training is down to a 'T'. If my training has run out, I can't move and handle someone safely. However, we saw the training staff received was not always put into practice, for example we observed unsafe moving and handling practice. The registered manager checked staff's competence however, these checks were not effective because people were not moved safely and the provider's medication policy was not followed.

Records showed staff had completed or were working towards level two or three qualifications in health and social care. This meant staff should have the right skills and knowledge to provide effective care and support to people. Staff told us they had also completed training that supported them to understand and meet

some people's specific needs. For example, some staff had completed a level 2 qualification in dementia. The registered manager explained this had helped staff to understand the condition, which had benefited the people who lived at the home.

Staff told us they had received an induction, to ensure they understood their roles and responsibilities when they had started working at the home. New staff members were supported by more experienced staff to help them learn about the needs of people who lived in the home. For example, they had worked alongside experienced staff and observed how people preferred to be supported before they worked unsupervised.

Handover meetings took place at the beginning of each shift when the staff on duty changed. Staff discussed the health and well-being of each person living in the home. A staff member told us the meetings were, "Really useful." Staff told us they knew if a person's needs had changed, because messages were often passed on verbally and the most senior person on duty completed a 'work allocation sheet' each day so they had up to date information about people and they knew what support to provide.

People told us they were satisfied with the food provided and had enough to eat and drink. Comments included, "The food is fairly good," "I ask for a sandwich sometimes, they [Staff] do it for me" and, "You can say 'can I have a cup of tea' and they will make you one." A relative told us, "Lunch is quite pleasant here. What I've seen of the food, it looks nice."

Staff demonstrated their knowledge of people's nutritional needs. For example, they knew who needed encouragement to eat, who was diabetic and who enjoyed a vegetarian diet. However, we saw people were not always supported effectively during meal times.

At lunchtime we observed people were not supported effectively to eat or to enjoy their meal. People were not always able to eat according to the preferences and some people did not receive the support they needed to eat. People were rushed and their plates were cleared away before they had time to say whether they had eaten enough or wanted something else. Lunch was served in the dining room. People had the choice of a casserole, a hot dog or burger. Desert was a choice of bananas and cream or sponge and custard. There were not enough desserts for everyone to have their preferred choice and some people were offered ice creams and cakes instead. Meals were plated and shown to people to assist them in making their choice, which was supportive of people who might not have understand verbal description of the choices. Some people had been provided with adapted cutlery and plate guards to help them eat their meals independently.

Some people who chose to have a hot dog or burger were told by a member of staff to, "Just eat with your hands," in a loud tone of voice across the room. One person continued to try and eat their bread roll unsuccessfully with a knife and fork. It was evident that the person was struggling to cut the bread, but no further assistance was provided by staff.

Staff started to clear away people's plates before they had finished eating. One member of staff asked people, "Are you finished?", but did not give them time to answer. People were not encouraged to eat more of their meal when it was evident they had only eaten a few mouthfuls of food. The registered manager told us they were not satisfied with the food that had been provided to people. They explained that the cook had not followed the menu. It was not clear why this had happened or why checks of the food that was being cooked had not taken place. They acknowledged that the experience had not been positive for people. They assured us they would take actions to address the concerns we had raised.

Where people were at risk of dehydration or malnutrition this was identified through the risk assessment

process. Some people needed their food and fluid intake monitored by staff using a chart system. We looked at a selection of these records and they had been completed consistently. This showed us people had eaten and drank enough to maintain their health.

One person told us, "The doctor comes here usually." Another said, "The chiropodist comes." This assured us people saw the doctor and other health professionals when they needed to. However, records showed sometimes there was a delay in medical advice being sought. For example, it had been identified on 15 May 2016 that a person had lost 5kg in weight in one month. The person's GP was not contacted until 11 days later, which could have had a negative impact on the person's health. This same person was unwell on the 13 June and required emergency medical assistance from paramedics, who advised the person needed to see their GP. Staff had contacted the person's GP to request a home visit and the registered manager confirmed this visit had taken place. However, the visit and any advice provided by the GP had not been recorded in the person's records by staff. Therefore, it was not evident if any advice had been shared with staff to ensure the person was provided with the support they needed to maintain their health at this time.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were caring. Comments included, "Yes, no problems with them [Staff], "They are quite nice, they always include you." And "Oh yes, I think they do care about me." They told us this made them feel happy because someone was 'looking out for them.' Relatives were complimentary about the staff. One said, "They are lovely." Another said, "Generally on the whole they [Staff] are caring."

Despite what people had told us we observed people's privacy was not always respected. On three separate occasions' staff entered people's bedrooms without first asking their permission. On one occasion we were talking to a person in their bedroom and a member of staff came into the room. They did not knock the door or wait for permission before entering. They said, "Here's your tea [Person]," and then walked out.

People told us staff did not always seek their consent particularly before delivering care and support. Comments included, "They [Staff] come in and get on and do it." "Some knock, some don't, they don't ask my permission normally." And, "They knock and I say, come in; they [Staff] don't ask me if it's ok." We discussed this with the registered manager who assured us they would remind the staff of the importance of obtaining people's consent to ensure people's human rights were respected.

Not all the staff supported people to maintain their dignity. We observed some staff spoke to and about people in a non-caring manner. For example, at lunchtime we overheard two members of staff talking to each other in a disrespectful way about people. One person had requested a dessert which was not on the menu. A member of staff said to the person "There's always one," in a negative way .

We saw most of the staff were trying their best to provide person-centred care. We spent time in the communal lounge. We saw people were supported by staff who knew people's abilities, support needs, habits, and preferred routines. They were caring in their approach but at particular times during the day, we saw interactions with people were limited to when they offered support or completed a care task. We asked staff if they had enough time to sit and chat with people to get to know them. One said, "No, not really, I would like more time." Another said, "Not always."

However, some staff did not take the time to engage and communicate with people when they had the opportunity. For example, we saw a member of staff supporting someone to have a drink in the lounge. The member of staff stood over the person and made no eye contact or any attempt to talk with the person. We asked another member of staff about this person and they said, "She [Person] does try to communicate with you. If you sit and talk with her she will acknowledge you are talking with her." Therefore, the member of staff who had provided the support had missed the opportunity to turn the support they were providing into a caring and meaningful interaction.

Staff told us they aimed to promote people's independence where this was possible. We saw staff were patient when walking alongside people. For example, we heard a member of staff say to someone, "No rush, take your time you can do it." The person responded well to this and smiled. Staff told us it was important to this person that they could walk around the home independently and they encouraged them to do this. We

noticed that clocks and calendars showed the correct date and time, which supported people to stay orientated in time and promote their independence.

People were encouraged to maintain relationships that were important to them. People told us their visitors were welcome at any time. One person said, "I get my family visits. I don't think there are any restrictions." Another told us, "No restrictions on visiting." A relative explained they visited whenever they wanted to and they always felt welcomed at the home.

People's bedrooms contained their personal belongings and people told us they had bought their family photographs with them when they moved in. One person told us, "It made me feel a bit more settled and at home." However, in one persons' bedroom we saw a walking frame which did not belong to them. It belonged to someone who no longer lived at the home which did not demonstrate person-centred care. The registered manager removed the walking frame immediately but they were not sure why it still remained at the home.

We saw some people shared bedrooms and they had been consulted about who they shared with. However, we could not be sure that information about these people remained confidential. For example, records relating to their care were kept by their bed. This meant people's information was accessible to other people and their visitors. The registered manager told us they would remove this information immediately.

Information about a local advocacy service was on display in the home. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to help them to make a decision. We saw one person had an advocate who assisted them to manage their finances.

Requires Improvement

Is the service responsive?

Our findings

Discussions we had with people and their relatives indicated that staff were responsive to their needs and they knew what they liked and disliked. Comments included, "I think so, I don't have any dislikes", "I think so, don't dislike anything really" and "I think they have got to know [Person] by now. She tells them what she likes and dislikes."

Prior to admission to the home, people's needs were assessed to determine their level of independence, abilities and support needed. The registered manager explained this process was important as it made sure the home was the right place for the person to live and to ensure their needs could be met there. They explained they invited people's relatives to a meeting and the information they gathered was used to write a care plan. However, we asked people if they had been involved in planning their care so it was personalised to meet their needs and we received mixed feedback. Responses included, "No, I haven't", "I don't know what a care plan is, not really", "Not so I can remember," and "They do go through things with me." Therefore, we could not be sure the provider had taken action to ensure people's wishes and preferences were identified, listened to and considered when delivering care.

Staff knew the people they cared for well and how to support their needs. For example, staff knew that a district nurse had provided specific guidance on how a person's personal hygiene needed to be maintained. They explained to us in detail how this support was provided each day and what the impact on the person would be if they did not follow the guidance.

However, we looked at four people's care plans and three contained insufficient information for staff to follow to meet people's needs. More information was required to ensure people received personalised care in accordance with their preferred routines, likes and dislikes. For example, one person became anxious when staff used equipment to help them to move. It was not documented how staff were to reassure the person at this time. Records stated staff should, 'Ensure the person sat in a chair with arms so they could push themselves up with staff support.' However, on the day of our visit the person had chosen to sit on a sofa. There was no guidance to indicate how staff were to safely move the person when they chose to sit on a sofa instead of an armchair. We observed staff helped them to move using an underarm technique which had potential to cause harm to the person and to staff.

Another person's care plan stated, 'Staff to be alert for facial expressions and body language to indicate [Person] needs/wants something.' There was no further information available to assist staff to know what those expressions or body language might look like, or what they might need according to an identifiable facial expression.

Staff told us how they supported people to make choices. For example, they told us they held up two jumpers and the person chose which one they would prefer to wear. This showed us the staff understood how to communicate choices in a way people understood. However, we saw choices were not always offered. For example, at lunch time a staff member put on some music without consulting any of the people in the room and without checking it was to their liking. People were also handed biscuits rather than being

offered the tin to choose their own.

People were satisfied with the social activities on offer. A timetable of social activities was on display for people to look at. One person told us, "I have gone down in my wheelchair and played bingo. I can't think of anything else I've played." Another said, "There's bingo and keep fit." The activities co-ordinator told us they had worked at the home for ten years, so they knew people well and provided activities people enjoyed. We saw a musical activity taking place. Music from different eras was played and people were encouraged to sing along and join in. Another person preferred to sit quietly and complete a jigsaw puzzle.

We saw that the provider had taken some action to help orientate people around the home, such as signage and people's photographs displayed on their bedroom doors. The registered manager was aware of guidance and best practice to support people living with dementia. They told us they had plans to make the environment friendlier for people who live with dementia. They were planning to gather information to make memory boxes, which would be filled with people's treasured possessions and photographs to help people establish themselves in the home and also to help to trigger conversations between people.

People's relatives told us that overall they felt informed about their relation's wellbeing but they were not regularly involved in care reviews. One said, "I'm not involved with reviews, my brother and sister do that. My brother keeps me informed. The manager speaks to me when we come if needed." Another told us, "They keep us informed of any changes when we come. No official reviews."

People and their relatives did not have the opportunity to get together formally to feedback any issues or concerns about the service provided at the home. Meetings for people who lived at the home and their relatives did not take place. One person said, "No, we don't have anything like that here." The registered manager told us this was due to not many people attending previous meetings. They explained they were always available to speak with people and their families. They were planning to hold informal meetings in the next few months combined with coffee afternoons in an attempt to improve attendance.

A copy of the provider's complaints procedure was on display in the home and people we spoke with knew how to make a complaint if they wished to do so. There was also information about external organisations people could approach if they were not happy with how their complaint had been responded to. One person said, "I've not made a complaint. I would feel okay mentioning any problems." A relative told us. I would go straight to [registered manager] if I wanted to complain." We asked a staff member how they would know if someone was unhappy, if they were unable to tell them. They said, "I know people well, I would know if they were unhappy and I would let a manager know."

We looked at the complaints file maintained by the registered manager. No written complaints had been received in the last twelve months about the service provided. A variety of thank you cards were on display in the foyer and this showed us that people were, overall, happy with the service provided.

Requires Improvement

Is the service well-led?

Our findings

Processes and arrangements in place to ensure that people received safe quality care were not always effective. For example, there were not enough staff available at certain times of the day when people needed them. This meant people did not receive the care and support they needed to keep them safe, in order to meet their needs. The increase made to the staffing levels implemented by the provider following our last visit had not been sustained. A dependency tool to assess people's level of need was in use. However, it was not clear how the information had been used to decide the staffing levels.

Processes to identify risks related to the health, safety and welfare of people living in the home were not sufficient to ensure people were kept as safe as possible. For example, checks of the environment took place. However, we identified hot water pipes were not covered in a room which was accessible to people. The hot pipes could cause serious harm to a person's skin if it came into contact with the pipes. The registered manager had not identified this risk. They told us they would inform the maintenance team immediately and arrange for the pipes to be covered and a lock to be fitted on the door to reduce the risk to people.

Processes to manage other risks were not sufficient. The registered manager told us they completed quality audits and checks to assess how the home was being run to improve the quality and safety of services provided to people. We saw checks had taken place. However, some audits were not effective. For example, checks on medicines had not identified prescription creams were not being applied as prescribed and people's confidential information was accessible to others. Completed audits were sent to the provider but it was not clear how this information was used to ensure the home was being run in-line with the provider's policies and procedures to ensure people were kept safe.

We saw records were not always accurate. Information was not sufficient to ensure staff had the information they needed to reduce the risk to people's health and well-being. Care records were not sufficiently detailed to support staff in delivering personalised care that was in accordance with people's preferences and wishes. The competence checks of staff practices were not effective because staff did not demonstrate their learning to ensure they delivered safe care in accordance with instructions, which put people at unnecessary risk.

Accidents and incidents were recorded but they were not analysed, to ensure lessons were learnt and actions were taken to minimise the risks of a re-occurrence.

Staff told us they enjoyed working at the home and the registered manager was approachable. However, they voiced their concerns about the senior leadership of the home. They explained they did not feel valued and supported by the provider, which meant some staff were leaving to seek alternative employment. One member of staff said, "We never see them [provider]. We very rarely see anybody from the head office come over." Another said, "It's not fair, we need more staff, they [provider] know. She [registered manager] tries her best but she is left to get on with it by them [provider]." This made them feel frustrated, which they felt had had resulted in a negative impact on staff morale. The registered manager told us they were recruiting

new staff. They told us they felt staff were leaving to seek other employment opportunities.

We asked the registered manager if they felt supported in their role because records showed they did not have regular meetings with their line manager to discuss their performance at work. They told us, "Sometimes. I feel supported by the staff and the local authority and I can phone head office if I need help." We discussed this with the provider's quality and compliance manager, because records showed senior managers rarely visited the home. For example, the last quality check was undertaken by the provider over 12 months ago. The quality and compliance manager told us, "Registered managers can request meetings at any time." They explained they were in the process of implementing new procedures, which will include more frequent visits to the home by senior managers to make checks and provide support to the registered manager.

The registered manager told us they encouraged feedback from people, their relatives and staff. However, group meetings involving people who lived at the home and their relatives did not take place. We saw a locked box in the foyer of the home for people to put their suggestions and complaints into. The registered manager told us they did not have a key to open the box. The key was held by senior managers who did not work at the home. As we had already identified senior managers had not visited the home in the previous 12 months, it was not clear how regularly this feedback would be reviewed and acted upon.

This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our concerns people thought the home was well-run. One said, "I don't think I want anything changing, 9/10." Another said, "She's alright she is, [registered manager]. I've never asked to see her." Relatives told us "It's a very good atmosphere, very pleasant. The manager is always around" and, "Whenever I've rung to speak to [registered manager] she's there. If not she phones me back."

The provider's management team consisted of a registered manager and a deputy manager. The registered manager was experienced and had worked at the home for the past ten years. They told us they were committed to the continual improvement of the home and the care people received. They told us they conducted daily 'walk arounds' of the home and this ensured they had an overview of how staff were providing care and support to people and gave them the opportunity to speak with people and staff. However, our observations during our visit did not assure us the 'walk arounds' were always effective.

The registered manager told us they met individually with staff members every 8 weeks to provide them with support to be effective in their role. The meetings also gave staff opportunities to talk about their work performance and personal development. Staff confirmed meetings took place.

Staff told us they were given some opportunities to meet as a team with the registered manager where they could contribute their views and make improvements within the home. One told us, "They are okay [team meetings]. It is really to touch on what things could be improved in the home, but it is all done by the manager."

Questionnaires about the home had been sent to 26 people and their relatives in November 2015. In total 12 responses had been received and analysed. Overall, people were happy with the care they received and comments included, "I am very pleased with the service my wife is getting, could not get better." And, "I am happy with the care." The registered manager assured us action would have been taken if improvements had been required. In May 2016 surveys had been sent to 26 members of staff to gather their views on the

home and their employment. At the time of our visit no staff had responded. We asked staff about this and one said, "What's the point, things won't change here." Another told us, "I will respond, I just haven't had time yet".

We asked the registered manager what they were most proud of at the home. They said, "React to red skin accreditation." This was an accreditation awarded to the home by local health professionals, because staff at the home were skilled at recognising the early signs of when a person's skin was at risk of being damaged. We checked and nobody at the time of our visit had damaged skin.

The registered manager told us which notifications they were required to send to us so we were able to monitor any changes or issues within the home. We had received the required notifications from them. They understood the importance of us receiving these promptly so that we were able to monitor the information about the home.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Administration of prescription creams and ordering of medicines required improvement. Creams were stored in people's bedrooms which presented a risk. Creams were applied by care staff, but the plans in place to ensure these were applied as prescribed were not sufficient. The dates of when creams were opened were not being consistently recorded. This presented a risk. We could not be sure checks taking place were sufficient.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems and processes to monitor and improve the quality and safety of services provided to people were not in place. Quality audits and checks were not effective. Records were not always accurate and staff were not using care plans to ensure they delivered safe care in accordance with instructions which put people at unnecessary risk. There was no system to effectively involve people in their care which meant care was not person centred. There were no relative or resident meetings.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had decreased the number of staff so three care staff were on duty during the afternoon and early evening. We saw that staff

were busy at this time and were task orientated, which meant they had little time to interact with people and keep them safe. We observed staff tried to be responsive to people's needs. However, assistance was not always provided at the time people required. Staff told us there were not enough of them to keep people safe and meet their needs.