HICA

Albemarle - Care 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?	Good
Is the service well-led?	Requires Improvement

Overall summary

Albemarle provides accommodation for up to 42 people who need support with their personal care. The service mainly provides support for older people and people who are living with dementia.

Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The service has all single bedrooms and nine bedrooms have en-suite facilities. There were 40 people living in the service at the time of our inspection.

This inspection was unannounced and took place on 4 November 2014. During the inspection we spoke with the four people who used the service, four visitors to the service, four staff and the registered manager. 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.

Summary of findings

The last inspection took place on 19 December 2013. At that inspection we found the provider was meeting all the essential standards that we assessed.

Although people told us they felt safe in the service, we found they were not fully protected from the risks of infection. There was a significant and unpleasant odour in one of the communal areas and the corridor carpets were heavily stained. People who used the service, relatives and visiting health and social care professionals had all given feedback on cleanliness to the provider using the systems to assess the quality of the service, but no action had been taken. This meant the quality monitoring processes were not effective as they had not ensured that people were provided with a clean environment in which to live.

Some people who lived in the service were not able to make important decisions about their care due to living with dementia. We saw that steps had been taken to make sure people who knew the person and their circumstances well had been consulted to ensure decisions were made in their best interests. However, some people who used the service were subject to a level of supervision and control that amounted to a deprivation of their liberty without a standard authorisation being in place. This meant there were inadequate systems in place to keep people safe and protect them from unlawful control or restraint.

People told us that they, and their families, had been included in planning and agreeing to the care provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives. All of the people we spoke with said they were well cared for. They told us staff went out of their way to care for them and all said that it was a lovely place to live.

Staff received a range of training opportunities and told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

People's nutritional needs had been assessed and they told us they were satisfied with the meals provided by the service. People had been included in planning menus and their feedback about the meals in the service had been listened to and acted on.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the service. People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to protecting people by maintaining the service to a clean and hygienic standard, Deprivation of Liberty Safeguards and not monitoring the quality of the service well enough. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of this service were not safe.

People who lived in the service were placed at risk because some areas of the service were not cleaned to a hygienic standard.

Staff were recruited safely and trained to meet the needs of people who lived in the service.

There was sufficient staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

Staff employed by the provider knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

Some aspects of this service were not effective.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards(DoLS). We found the provider was not meeting the requirements of the Deprivation of Liberty Safeguards.

Although the registered manager and staff understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), ineffective systems to check that people had up to date standard authorisations in place meant some people were being deprived of their liberty unlawfully.

People reported the food was good. They said they had a good choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People reported that care was effective and they received appropriate healthcare support.

Is the service caring?

Good

The service was caring.

All of the people we spoke with said they were well cared for and we saw that people were treated in a kind and compassionate way. The staff were friendly, patient and discreet when providing support to people.

All of the people we spoke with said that they were treated with dignity and respect and we observed this throughout our visit.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Good

The service was responsive.

Summary of findings

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People were able to make choices and decisions about aspects of their lives. This helped them to retain some control and to be as independent as possible.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Some aspects of the service was not well-led.

Although there were systems to assess the quality of the service provided in the service we found that these were not effective. The systems used had not ensured that people were not always protected against risks about infection control and inappropriate care and treatment relating to DoLS.

The registered manager made themselves available to people and staff. People who used the service said they could chat to the registered manager, relatives said they were understanding and knowledgeable and staff said they were approachable.

Staff were supported by their registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their registered manager.

Requires Improvement

Albemarle - Care 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 checked 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 unannounced inspection took place on 4 November 2014. The inspection team consisted of an adult social care inspector and a second inspector.

Before our inspection we reviewed the information we held about the service, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection. And we contacted local commissioners of the service, GPs and community nursing teams who supported some people who lived at Albemarle to obtain their views about it.

During our inspection we spoke to the registered manager and four care staff. We spoke with four people who used the service and four relatives. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes. We observed care and support in communal areas, spoke with people in private and looked at the care records for three people, three staff recruitment records and records relating to the management of the service. We looked at induction and training records for three members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who used the service. We also spoke with staff about their experience of the induction training and on-going training sessions.

We did not use the Short Observational Framework for Inspection (SOFI) because almost all of people that used the service were able to talk with us. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

People who used the service were not safe because they were not protected against the risk of infection.

We found problems with the cleanliness and hygiene of some parts of the service. There was a significant and unpleasant odour in one of the communal areas and the corridor carpets were heavily stained.

People had commented in the June 2014 satisfaction questionnaires that, "The service is sometimes malodourous", "The service is clean but needs a change of flooring in some areas", "Very strong urine odour in blue lounge" and "Odours noted on entering the service".

As part of our inspection process we had contacted commissioners and health and social care teams who visited the service to ask about their views of the service. We received information that indicated that they had noted concerns about odours in the service during their visits to the service. One person said, "A colleague visited about a month ago and informed me that there was an excess odour of urine around the service. I also have visited recently and although I think the odour problems had reduced the service does seem to have an on-going problem that the registered manager states she is addressing."

We discussed the odours in the communal area and the stains on the corridor carpet with the registered manager. They told us the domestic staff cleaned the communal and corridor areas each month with a carpet cleaning machine. We saw records that showed the carpets had been cleaned in September and October 2014. We also the environmental audits completed by the registered manager in 2014 identified the odours in the communal areas. These audits were checked by the area manager on their monthly visits to the service. We saw that the provider had not taken action to ensure people were provided with a clean environment to live in. The area manager assured us that the flooring in the communal area would be replaced as soon as possible.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the recruitment files of two care staff and one ancillary staff employed to work at the service. Two staff had started work in the last year and the third staff member was a long term employee. In all three files the application forms were completed and two or three references obtained before the person started work. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

The provider's recruitment policy and procedure stated that staff should only start work on receipt of a disclosure and barring service check (DBS) that was deemed satisfactory. This check is carried out to ensure that people who used the service are not exposed to staff who were barred from working with vulnerable adults. In one file we saw that one person had started before the DBS check was received so we checked other files. We found this was an isolated occurrence and the DBS was received shortly after they started work.

We discussed the recruitment process with the registered manager and area manager. Both individuals confirmed that this member of staff's recruitment had not followed the usual process. The registered manager said that there had been some problems getting the DBS check through, but the person was supervised at all times until their DBS was received.

People told us they felt safe living in the service. People who could speak told us, "The service is safe at night. The locks on the external doors means people cannot get in and out without staff knowing about it. You can go out with visitors or the staff when you want". Two relatives said, "This is a brilliant service. Very safe and secure" and another visitor commented that, "Yes, the service is secure. My relative is safer here than at their own home".

Providers of health and social care services have to inform us of important events which take place in their service. The records we hold about this service showed that the provider had told us about any safeguarding incidents and had taken appropriate action to make sure people who used the service were protected.

The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse (SOVA). The registered manager described the local authority safeguarding procedures. They said this consisted of a risk assessment tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. There had been instances when the

Is the service safe?

safeguarding risk matrix tool had been used, when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. One staff member told us, "The numbers for the safeguarding team are above the fax machine so we can contact them if we have any concerns."

Staff said they were confident their registered manager would take any allegations seriously and would investigate. The staff told us that they had completed SOVA training in the last year. The training records we saw showed that all of the staff were up-to-date with safeguarding training and this was renewed annually.

The provider had processes in place to look after people's personal allowances. Individual records of all transactions were kept, with receipts. Printouts were available to families or people who used the service on request. People told us they were happy with the financial arrangements in place. One person said, "I leave my money in the safe and get it whenever the manager or administrator are available. This has never been a problem. I could get my money out in advance if needed" and another person told us, "My finances are in joint names with my next of kin so I have no worries. They act on my behalf and sort things out for me."

We looked at the provider's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

One staff member told us, "There is a file in the office for emergencies, out of hours professionals and other people such as contractors. The main office is the meeting place in case of fire and I would contact the area manager if needed. If we had people with diarrhoea and vomiting I would inform the health care professionals. We have policies to follow as needed. Staff have pagers on them, if someone calls for assistance the pager goes to the call bell automatically and goes faster in an emergency."

We saw rotas indicated which staff were on duty and in what capacity. The rotas showed us there were staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of care staff, domestic and laundry assistants, administrator, activity co-ordinator, catering staff and maintenance personnel. In discussion, the registered manager told us that, "Staffing has increased on an afternoon as recent analysis of safeguarding incidents showed this was a problematic time; so the provider agreed an increase."

We observed that the staff were busy, but organised. Staff worked in and around the communal areas throughout the day and we found that requests for assistance were quickly answered. We asked people if they were happy with the staffing levels. One person said, "Yes there are enough staff and plenty of cleaners", another person said, "They are always around when you need them" and two relatives told us, "The staffing levels are good. They always tell us about our relative's needs. I think they are here for me as well. Very supportive."

We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The senior care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files.

We observed staff giving out medicines at the lunch time meal. Staff communicated effectively with people, even those who could not say if they were in pain or in need of anything. Staff told us, "We know the people who use the service. We look at their posture, their facial expressions and the majority of people can use gestures to let us know how they are feeling." Two people said, "The staff watch my tablets for me. I am happy for the staff to give me my medicine as I would forget to take it" and "The staff give me my medicines that I have been on for a long time. I also have drops in my eyes, which I couldn't do myself."

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests.

The PIR completed by the provider indicated that one person at the service had a DoLS in place and this was confirmed by the registered manager during our inspection. The paperwork in the person's care record showed the steps which had been taken to make sure people who knew the person and their circumstances well had been consulted. This ensured decisions were made in their best interests.

However, information in the person's care record indicated that the DoLS authorisation ran out in August 2014 and a new application had not been submitted. Discussion with the registered manager showed that they had not recognised there was a time limit on the DoLS authorisation. In discussion with the registered manager and area manager it was confirmed that the person who had been under a DoLS authorisation continued to be subject to a level of supervision and control that amounted to a deprivation of their liberty.

The registered manager and area manager assured us that a new application would be completed immediately and sent to the authorising body. We were also told that the manager and deputy manager were booked to attend DoLS training provided by the local council the day after our inspection.

This was a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed the MCA with the registered manager. They showed that they were knowledgeable about how to ensure that the rights of people who were unable to make or to communicate their own decisions were protected. We looked at care records which showed that the principles of the MCA Code of Practice had been used when assessing an individual's ability to make a particular decision.

For example, some people who lived in the service were unable to make important decisions about their care due to living with dementia. Senior staff in the service were knowledgeable about the MCA. Staff told us, "If a person does not have capacity then some decisions could be taken for them after a best interest meeting. Day to day life decisions can still be their own. You can involve a person's GP or community psychiatric nurse (CPN) if their mental health needs are deteriorating. You would always assume capacity and offer daily life choices."

We contacted local commissioners of the service and safeguarding teams before our inspection.

None of the individuals we contacted raised any concerns about how people who used the service were supported to maintain their mental health and physical wellbeing.

When people displayed particular behaviours that needed to be managed by staff in a specific way to ensure the person's safety or well-being, this information was recorded in their care plan. Staff told us that restraint was not used within the service. The staff were able to describe what they would do if an individual demonstrated distressed or anxious behaviours. Staff said, "We would try to guide a person to a place of safety and sit with them on a one to one basis until they relaxed" and "It is important to keep calm and if need be move other people out of the way."

Where people had someone to support them in relation to important decisions this was recorded in their care plans. Records we saw showed that peoples' ability to make decisions had been assessed. They showed the steps which had been taken to make sure people who knew the person and their circumstances well had been consulted to ensure decisions were made in their best interests. One relative told us, "The staff are very caring and considerate. There are no restrictions on my partner's daily life and the staff always talk to me about their care and support."

Staff told us they were confident they had the skills and knowledge to meet the needs of people who used the service. Staff told us they had completed a block induction programme lasting a week prior to commencing in post. This covered all aspects of mandatory training such as SOVA, moving and handling, fire safety, infection prevention and control and health and safety. Following induction training, staff had completed refresher training on these topics. Staff also said they 'shadowed' experienced staff until they were confident about working unsupervised.

We looked at the records around staff training which showed that all staff had completed a range of training relevant to their roles and responsibilities. This included

Is the service effective?

training to keep people safe, such as in moving and handling, infection control, food hygiene and fire safety. In addition, care staff had either completed or were undertaking a qualification in Health and Social Care.

The provider had good systems to record the training that staff had completed and to identify when training needed to be repeated. Each staff member had a file with a personal plan of training they had attended and the certificates that they had been awarded. There was also a spread sheet which clearly recorded when each member of staff had last completed a training course and when the training needed to be repeated. This was then booked by the registered manager as required.

Records of staff supervisions showed that care staff were observed as part of their supervision in order to provide feedback about their practice. We looked at three staff supervision records. These showed that supervision meetings were held every six weeks. Staff who spoke with us said they found this helpful as they were able to discuss their work and get feedback on their working practice.

Everyone we spoke with told us that people were well cared for in this home. People told us, "I have no complaints about the staff, we have a laugh and I couldn't say what could be improved" and "You can make your own choices. I like to go to bed at around 10pm and get up around 8am. Staff always check on you to ask if there is anything you need." One visitor to the service told us, "Staff skills seem okay and they interact well with people. Staff take people to hospital and GP appointments in their wheelchairs. I have experienced good communication with staff about such things as falls and illness in relation to my relative."

People who could speak with us told us that they received the support they required to see their

doctor. One person said, "I see my own GP and the district nurse on a regular basis." Some people who lived in the service had more complex needs and required support from specialist health services. Care records we looked at showed that some people had received support from a range of specialist services such as the Parkinsons nurse, mental health team and diabetes specialist nurse.

In discussion, staff were able to say which people had input from the district nurse or dietician; they also knew what health problems each person had and what action was needed from them to support the person. Entries in the care records we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. Our observations showed that staff treated people with respect and dignity whilst assisting them to eat and drink.

We observed the second sitting of the midday meal in the dining room. The meal time was organised and people were quickly provided with a drink and their choice of food. Staff asked if people needed support with cutting up their food and plate guards were made available where needed, to help people be independent with their eating. We saw staff and relatives sat at the side of people, helping them to eat and drink. All interactions with people were carried out quietly and respectfully so people's dignity and independence were promoted throughout the meal time.

There was a relaxed and unhurried atmosphere in the dining room, so people were able to eat at their own pace and without interruption. People were chatting with each other and the staff and the meal time experience was a very social one. People were very satisfied with the food provided. One person told us, "We get a choice of meals, usually at least two on offer. You can take it or leave it, but there are always alternatives available. We are never hungry. I am trying to get my weight down so that I can fit back into my trousers." Another person said, "It is very good food and there are lots of choices. You can have extra helpings if you want." One visitor told us, "I have no issues with the diet given to my relative. I have had a couple of meals here and it was always good quality food."

The registered manager had undertaken training in Dementia Care Mapping provided by Bradford University. This involved the registered manager sitting and observing how people interacted with each other and the staff. The conclusions from these observations were then used to improve people's daily lives. We saw in the care records that the registered manager had mapped people's dining experiences and updated people's support plans accordingly. One person's care record documented that they were, "Unsettled over lunchtime, would benefit from staff sitting with whilst eating." Our observations of the meal time showed that this was now taking place.

The provider told us in the provider information return (PIR) that when looking at the effectiveness of the service's environment they took into account good practice for Design in Dementia Care. They were aware that colour

could be used to increase and reduce visibility and colour contrasts could help people's navigation and orientation skills. We saw plain carpets were used in the corridors and bedrooms, bedroom doors were painted in bright colours and toilet / bathroom doors had pictures on them. This enabled people to find their way to the different amenities and reduced their confusion and anxieties.

People had access to outdoor spaces and garden areas that took into account the needs of people with dementia. In the last year the provider had upgraded the gardens around the service, creating a secure area with flat walkways enabling people to walk independently or with support. The gardens included a sensory area, a water feature and bird feeding stations so there were things for people to do and see whilst sat outside.

Is the service caring?

Our findings

People who spoke with us were very satisfied with the care and support they received from the staff and made a number of very positive comments. People told us, "We have no complaints about our care at all", "I need help in a morning and the staff are always kind and friendly" and "I need someone to watch out for me. The staff understand my medical problems and how they affect me in general."

We spoke with people who were visiting their family in the service and they told us, "My relative can talk to the staff if they feel unwell and the staff always sort it out for them", "I am really happy with the service, couldn't ask for better care" and "Our relative has come on in leaps and bounds since coming in here. They have put on weight, are able to get dressed by themselves and they are safe in this home."

Throughout our inspection we saw that there were good interactions between the staff and people, with friendly and supportive care practices being used to assist people in their daily lives. One person who used the service told us, "The staff are very discrete with personal care. They do not make you feel uncomfortable when you need help, they respect your dignity."

We observed many positive interactions and saw that these supported people's wellbeing. We saw one member of staff being greeted by two people when they came on duty. One person asked the staff member if they would take them to the hospital for their appointment the following week and the staff member agreed. We were told by the individual, "All the staff here are good people, but I particularly get on with that one."

Staff took the time to speak to people during their working day and gave individuals their attention and time so that they could respond back and be listened to. We saw that people who could not communicate verbally were included within conversations and enjoyed a laugh or two, which raised their sense of well being.

People told us that staff explained procedures and treatment to them and respected their decisions about care. We observed staff talking to people whilst hoisting them from armchairs to wheelchairs. The staff explained what they were doing and what they needed the person in the hoist to do to help them. Staff checked people were okay with the process and that they were comfortable and not anxious. People told us they found this reassuring and knowing what was happening reduced their stress levels.

Staff were attentive to people who chose to stay in their bedrooms. We observed staff asking if individuals were okay, did they need any assistance and offering them drinks and snacks throughout the day. We saw one member of staff speaking to someone who was feeling unwell and was in bed. The staff chatted to the person even though they did not get a response, talking about local news and what was going on in the service. The member of staff told us, "Well you never know what people can hear and understand even if they seem unresponsive, I don't want them worried or upset about who is in their room, so I always make sure they know it is me and what I am doing there."

Families we spoke with told us that they were able to visit their relatives whenever they wanted. They said that there were no restrictions on the times they could visit the service. One person said, "I visit every day and all the family was here on Sunday. I am involved in my relative's care. For example, I am told about any hospital appointments and the staff order the medi-bus and I go with them. If I cannot make it then someone from the service will always go with them. There is not an expectation that you will go, but it makes me feel I can help."

The staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and decisions. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans. People who used the service told us that staff respected their wishes and would listen to them when they wanted to change things around.

Senior staff told us, "The care we give is monitored all the time. We review care plans, ask people about their care and consult with relatives when people are unable to make their own decisions. It is important to spend time with people, so we have sing a longs, look at photographs and go on trips out." One staff said, "We have more time in an evening to interact with people. I make sure I smile at people and make eye contact with them. I would have no hesitation in reporting to the manager if I felt any staff were not caring."

Is the service responsive?

Our findings

The staff we spoke with showed that they were knowledgeable about the people in the service and the things that were important to them in their lives. People's care records contained a 'map of life' and 'all about me' information. Having this kind of information assisted staff in understanding the person's needs, past history and experiences and in developing individual person centred care.

Staff knew what was recorded in individuals' records and used this to engage people in conversation, talking about their families or where they used to live. One person told us, "I like music and singing." We observed that the staff had made sure this person was included in the morning activities which involved people playing musical instruments and singing along to recorded songs. One person who had only just come into the service that morning was encouraged to join in and their relative said, "This is just what they needed, they have really picked up in mood."

People told us they enjoyed the activities on offer and visitors said they were also included in any events or social activities. One visitor said, "My relative chooses not to join in with activities. However, they have had entertainers that come into the service and perform and they do enjoy this."

In discussion, the registered manager told us that there were no specific dementia care strategies in place, but the manager was aware of various pieces of guidance and good practice especially those produced by the Department of Health, the National Institute for Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE). We were told the registered manager had joined the dementia care friends group and actively used the Bradford Model of dementia care mapping to improve the day to day experience of the service for people with dementia.

Using the mapping tool the registered manager had observed that some people needed more activities to stimulate their minds and promote their physical wellbeing. The registered manager told us that in July / August 2014 they had increased the hours for the two activity co-ordinators so there were activities taking place seven days a week during the day and evenings.

One person required additional one to one time so a member of staff was identified to chat with them and enable the person to sit and relax more. It was noted that another person required something to interact with so they were encouraged to sit with others and staff used snacks and drinks to tempt them to sit and join in with activities. A third person was encouraged to do gardening projects when it was seen they enjoyed being outside of the service.

Care records were written in a person centred way. We saw that staff reviewed the care plans on a monthly basis and the review notes indicated that this task was carried out with the person who used the service and their input and views formed part of the review. People we spoke with said they could talk with staff about their care, and their wishes and choices were respected by the staff.

One person told us, "My family come most days to visit me. It is not as bad as you think having to live in a home, you do have freedom and the staff do help you. I have not heard or seen my care records and I have not filled in any forms, but my daughter might have. I am satisfied with the care and support and my family think this place is the best place for me." Two relatives told us, "We are aware of our relative's care records and we can discuss any issues during the social care reviews or with the staff when we visit."

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. For example, in one care record we saw that the person had a history of falling and had received input from the falls team. We observed that this person was wearing a head protector as advised by the falls team and there were frequent reviews with their family to ensure their care was discussed and based on what was in their best interests. Checks of this person's care record showed that risk assessments and care plans for falls and moving / handling were in place and reviewed regularly. Details of health and social care professional visits were documented in the care record and there was good recording of the reasons for the visit, what was discussed and any action taken.

In discussions with staff they told us they had handovers at each shift change. They used this time to discuss the people who used the service and any concerns that had been raised. These meetings helped staff to receive up to date information about people. There were information

Is the service responsive?

sheets (patient passports) in care records for use when people were admitted to hospital to provide staff with important details about health needs such as mobility and personal care.

There was a complaints policy and procedure on display in the entrance hall of the service. This described what people could do if they were unhappy with any aspect of their care. We saw that the service's complaints process was also included in information given to people when they started receiving care. Checks of the information held by us about the service and a review of the provider's complaints log indicated that there had been one complaint made about the service in the last 12 months. This had been investigated by the manager and resolved quickly. People and relatives who spoke with us were satisfied that should they wish to make a complaint then the staff and the registered manager would listen to them and take their concerns seriously

One visitor said, "I have no complaints about the service and my relative could go to the manager if they had any issues" and one person who used the service told us, "If I had a problem I would tell the manager. My family have used the complaints process in the past and they were listened to and action was taken to put things right."

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service provided in the service we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report about infection control and inappropriate or unsafe care and treatment. We found problems in relation to odour in one part of the service, and one person being deprived of their liberty without a valid authorisation in place.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We sent the registered provider a provider information return (PIR) that required completion and return to CQC before the inspection. This was completed and returned with the given timescales.

There was a registered manager in post who was supported by a deputy manager. The PIR stated that the registered manager met with other managers working for the provider, including area managers, on a regular basis. These meetings had external speakers, good practice discussions and were an opportunity to share practice issues for learning. This was confirmed by the registered manager and area manager on the day of the inspection.

The information within the PIR enabled us to contact health and social care teams prior to the inspection to gain their views about the service. The teams who we contacted expressed no concerns about the service. One team said, "The manager has recently been extremely helpful with an emergency admission. This prevented an admission to hospital."

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. People who used the service and relatives had commented on the most recent survey sent out in October 2014. Individual comments included, "Home is pleasant", "Food is good and the entertainment", "Home is secure. It's friendly and staff and residents are like family", "Staff are busy but organised" and "Staff are friendly and considerate." We saw that most of the comments in the completed surveys were very positive.

People who used the service told us that they were asked for their views about the service. One person told us, "We have meetings and we can suggest things we want changed. I wanted to change my bedroom to one with an en-suite and they sorted this out for me." We saw records of the meetings which showed that people had been asked for their opinions and the action that had been taken in response to people's comments.

In May 2014 staff had completed a survey about activities and if they had any suggestions for how the service could be improved. The manager had assessed the responses and analysed the staff's understanding of the importance of activities especially for those people who had dementia. The results of the survey were discussed in the staff meeting held in June 2014. In August 2014 the manager increased the activity hours based on the results of feedback from staff, people and relatives, combined with the outcomes of their dementia mapping sessions.

We saw that staff had regular supervision meetings with a senior member of staff and that these meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff. Our checks of the staff files showed that senior care staff completed staff supervision meetings and documented the minutes of the meetings on the supervision records. These were monitored by the area manager during their quality audits.

People who used the service and their visitors said they knew the registered manager and would be confident speaking to them if they had any concerns about the service provided. People we spoke with knew the registered manager's name and said they had the opportunity to speak with them each day. One person said, "The manager is lovely, really friendly and always interested in what we are doing" and a visitor told us, "I can always get hold of the manager if I have any problems. They listen to you and sort out any difficulties."

All the staff we spoke with told us that they were well supported by the registered manager of the service. They told us the registered manager was, "Brilliant", "Really approachable" and "Supports us daily in any way we need." All the staff said that they would be confident to speak to the registered manager if they had any concerns about another staff member. They told us that they had no concerns about the practice or behaviour of any other staff members.

Is the service well-led?

The atmosphere in the service was open and inclusive. Staff spoke to people in a kind and friendly way and we saw many positive interactions between the staff on duty and people who used the service. One staff member told us, "The culture of the service is friendly, relaxed, but professional when we need to be." Other staff said, "The service is well led. We work in teams and the care is very good" and "We put the people who use the service first."

People who used the service told us, "I love it here", "We can always have a bit of banter with the staff, which makes the days go quicker" and "They look after us well. Nothing is too much trouble for them."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used the service were not protected against the risks associated with acquired infections because of inadequate maintenance of appropriate standards of cleanliness and hygiene in relation to the premises occupied for the purpose of carrying on the regulated activity. Regulation 12 (1) (2) (c) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who used the service were not protected against the risk of abuse because of inadequate arrangements to protect people from unlawful control or restraint in relation to deprivation of their liberty. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. Regulation 10 (1) (a) (b)