T.L. Care Limited

Beeches 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 3 May 2016 and was unannounced. This meant the registered provider did not know we would be visiting. The service was previously inspected in February 2015 and was meeting the regulations we inspected.

The Beeches Care Home can accommodate up to 64 people. The building is on two floors and is located in a residential area of Newtown, Stockton. At the time of our inspection 52 people were using the service, some of whom were living with a dementia.

There was a registered manager in place. 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.

Appropriate arrangements for the safe handling of medicines were not always in place. Controlled drugs were regularly assessed however stocks were not always recorded accurately. Room and fridge temperatures were not recorded on the ground floor and not recorded accurately on the upper floor. Care plans were not person centred for medicines administration as they did not have information about a person's preference for taking medicines. Medicines audits were completed however they lacked detail. 'As required' (PRN) medicine care plans were not always sufficiently detailed. People managing their own medicines did not always have completed risk assessments. The frequency of medicine administration was not always safely managed.

Risks to people were assessed and plans put in place to minimise the chances of them occurring. The service used recognised risk assessment tools to do this. Most risk assessments were specific and detailed how the risk could be minimised and how often it should be reviewed. However, we did see that some risk assessments for one person were lacking in detail and the registered manager said this would be reviewed.

Risks to people arising out of the premises were regularly reviewed, and remedial action taken where needed. Accidents and incidents were monitored by the registered manager to see if any trends were emerging and to ensure appropriate referrals where made if needed. The registered manager described how they used their accident analysis to make referrals to external professionals such as the falls team.
Plans were in place to evacuate people safely in case of emergency. A business continuity plan was in place in to help staff organise a continuity of care in a range of situations where the premises could not be used.

The premises were clean and tidy. Throughout the inspection we saw staff cleaning communal areas, and we noted that people's rooms were also tidy. Equipment was generally suitably stored, though we did see some continence pads being stored in a communal lounge. The area manager said these would be moved immediately. Throughout the inspection we saw staff using personal protective equipment (PPE) such as gloves and aprons to assist with infection control.

The registered manager and area manager both monitored staffing levels at the service. The registered provider had three other services in the region and these were used to provide staff to cover absences. Housekeeping and kitchen staff completed the same training as care staff, so were able to provide care support in emergency situations.

The registered provider's recruitment procedures minimised the risks of unsuitable staff being employed. Applicants completed an application form requiring them to detail their employment history and provide details of two referees. Written references were sought and Disclosure and Barring Service (DBS) checks carried out before applicants were employed.

Staff understood safeguarding issues and procedures were in place to minimise the risk of abuse occurring. Where concerns had been raised we saw they had been referred to the relevant safeguarding department for investigation.

Staff said they received the training needed to support people effectively. Staff received mandatory training in areas including manual handling, safeguarding, health and safety, infection control, pressure ulcer care, fire training, the Mental Capacity Act 2005 and nutrition. Training was regularly refreshed to ensure it reflected the latest best practice. Newly recruited staff completed induction training. This covered areas including the service's policies and procedures, health and safety and delivering care.

Staff felt supported by regular supervisions and appraisals. Records confirmed that staff were able to raise issues at supervision and appraisal meetings, which were used to discuss any training or support needs staff had.

The service was working within the principles of the Mental Capacity Act 2005. Where people lacked the mental capacity to make decisions about aspects of their care staff were guided by the principles of the MCA to make decisions in the person's best interest. For those people that did not always have capacity, mental capacity assessments and best interest decisions had been completed for them. Records of best interest decisions showed involvement from people's family and staff.

Consent to care and treatment records were signed by people where they were able. If people were unable to sign a relative or representative had signed for them.

People were supported to maintain a healthy diet, though records to support this were not always detailed. Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the food a person was taking each day, however portion sizes were not included. Fluid intake charts recorded the fluid a person was taking each day, however fluid intake goals and totals were not recorded.

People appeared to enjoy the dining experience, though there was some delay in people being served their food. We were told flash card menus were used to help people living with a dementia choose their meal, but this did not happen during the inspection.

People were supported to access external professionals to maintain and promote their health. Care records showed details of appointments with and visits by healthcare and social professionals.

People were treated with dignity and respect. Staff were polite and courteous when speaking with people, whilst at the same time being open and friendly. Where staff supported people we saw them asking for permission and working at people's own pace.

People and their relatives spoke positively about the care they received. Throughout the inspection we saw many examples of kind and friendly interactions between people and staff. Staff tailored their communication approach to ensure people could understand them. Staff said they enjoyed spending quality time with people and getting to know them.

The service supported people to access advocacy services. Procedures were in place to provide people with end of life care.

People's needs were assessed before they moved into the service. Care plans were then developed to meet people's daily needs on the basis of their assessed preferences. However, some of the plans we saw contained limited or no detail on how to meet people's needs and preferences. The registered manager said these would be updated.

The service employed an activities co-ordinator, who assisted people to access activities based upon their needs and preferences. We did note there were no specific activities for people living with a dementia. The activities co-ordinator was on leave during our inspection, and during their absence we noted there was limited activity provision at the service.

There was a complaints policy in place, and where issues had been raised these had been investigated and the outcomes communicated to the people involved.

The registered manager and registered provider carried out a range of quality assurance checks to monitor and improve standards at the service. Where issues had been identified by audits we saw that this usually led to remedial action but we saw this was not always the case.

Staff spoke positively about the culture and values of the service and the support they received from the registered manager. Staff and health and safety meetings took place to share information and allow staff to raise any concerns they had.

Feedback was sought from people using the service and staff through annual questionnaires.

The registered manager told us about the links the service had with the local community. The registered manager understood their role and responsibilities and the types of notifications that should be made to the Commission.

We found one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to medicines management. You can see what action we took at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed safely.

Risks to people were assessed and plans put in place to minimise the chances of them occurring, though some needed updating.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Staff had an understanding of safeguarding issues and the action they would take to ensure people were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to maintain a healthy diet, though records to support this were not always detailed.

Staff said they received the training needed to support people effectively and felt supported by regular supervisions and appraisals.

The service was worked within the principles of the Mental Capacity Act 2005 to protect people's rights while providing care and support.

People were supported to access external professionals to maintain and promote their health.

Is the service caring?

Good

The service was caring.

People spoke positively about the care they received at the service.

Staff protected people's dignity and treated them with respect when delivering care and support.

The service supported people to access advocacy services. Procedures were in place to provide people with end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were based on people's assessed preferences. However, some of the plans we saw contained limited or no detail on how to meet people's needs and preferences.

People were supported to access activities, though there were no specific activities for people living with a dementia.

Complaints were investigated and outcomes sent to the people involved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Issues identified by quality assurance audits usually led to remedial action but this was not always the case.

Staff spoke positively about the culture and values of the service and the support they received from the registered manager.

Feedback was sought from people using the service and staff through annual questionnaires.

The registered manager understood their role and responsibilities and the types of notifications that should be made to the Commission.

Beeches 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 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 3 May 2016 and was unannounced. This meant the registered provider did not know we would be visiting. The service was previously inspected in February 2015 and was meeting the regulations we inspected.

The inspection team consisted of two adult social care inspectors, a pharmacist inspector and a specialist professional advisor nurse.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the commissioners of the relevant local authorities and the local authority safeguarding team to gain their views of the service provided at this home.

During the inspection we spoke with four people who lived at the service and one relative. We looked at 10 care plans, medicine administration records (MARs) and handover sheets. We spoke with 10 members of staff, including the registered manager, the deputy manager, the area manager, care staff and members of the domestic, kitchen and maintenance staff. We also spoke with one external professional who works with the service. We looked at four staff files, including recruitment records. We also completed observations around the service, in communal areas and in people's rooms with their permission.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for medicines management. We looked at eight medication administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We also looked at storage, handling and stock requirements. We found that appropriate arrangements for the safe handling of medicines were not always in place.

Medicines were stored securely. Controlled drugs were regularly assessed however stocks were not always recorded accurately. Controlled drugs are medicines that are liable to misuse. Room and medicine fridge temperatures were not recorded daily on the ground floor and not recorded accurately on the upper floor.

Medicines were administered by a medicines trained care worker. We observed a care worker administering medicines safely during our visit. Care plans were not person centred for medicines administration as they did not have information about a person's preference for taking medicines.
Medicines audits were completed however they lacked detail. General storage audits did not detail which floor they had been completed on and any required or completed actions to make improvements were not recorded.

Some people were prescribed as required medications for pain relief and laxatives. Written care plans had been developed and these were kept with the MAR charts. However some of this information did not provide any detail about the signs and symptoms for use and were not person centred.

The service encouraged people to look after their own medicines if they were able to and a policy was in place. However, one person had not had the necessary paper work and risk assessments completed so there was a risk they might not receive the right amount of support to manage their medicines safely.

We observed two people who were prescribed pain relief patches and had their patch applied to the same skin areas more frequently than recommended. This meant there was risk this medicine might not be effective. One person was prescribed a medicine to be used for five days. The course however had been continued past the five days without consultation with the GP placing them at unnecessary risk.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Risks to people were assessed and plans put in place to minimise the chances of them occurring. Risk assessments were carried out in areas including medication, falls and diabetes. The registered provider used recognised risk assessment tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) to complete individual risk assessments, which helped identify the level of risk and appropriate preventative measures. Most risk assessments were specific and detailed how the risk could be minimised and how often it should be reviewed. However, we did see that some risk assessments for one person did not contain specific details on how those risks could be reduced or how regularly they should be reviewed. The same person was assessed as requiring monthly falls risk assessments, but this had

not been done in February 2016. We told the registered manager and deputy manager about this, who said the assessments would be reviewed.

Risks to people arising out of the premises were regularly reviewed, and remedial action taken where needed. Checks of areas including water temperatures, wheelchairs, fire alarms, fire extinguishers and the call system were carried out regularly by maintenance staff. Remedial action needed was monitored by the registered manager and area manager. Required test and maintenance certificates in areas including electrical and gas safety, weighing scales calibration and emergency lighting were in place.

Accidents and incidents were monitored by the registered manager to see if any trends were emerging and to ensure appropriate referrals were made if needed. The registered manager said there had been an increase in falls in January 2016, and their monitoring identified the cause as an increase in chest infections in winter. The registered manager described how they used their accident analysis to make referrals to external professionals such as the falls team.

Plans were in place to evacuate people safely in case of emergency. Each person had a personal emergency evacuation plan (PEEP), stored in a 'file folder' located in the reception. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. Each person's PEEP contained details on their support needs and how they could be best supported to safely evacuate the building. Regular fire drills were undertaken to help people and staff familiarise themselves with emergency procedures. A business continuity plan was in place to help staff organise a continuity of care in a range of situations where the premises could not be used, for example utilities failure or severe weather.

The premises were clean and tidy. Throughout the inspection we saw staff cleaning communal areas, and we noted that people's rooms were also tidy. Equipment was generally suitably stored, though we did see some continence pads being stored in a communal lounge. The area manager said these would be moved immediately. The area manager also said the registered provider was in the process of replacing carpets in a lounge on the first floor as these had become slightly odorous due to drinks spillage. Housekeeping staff told us they had all of the equipment they needed to keep the premises clean. One told us, "We get everything we need to clean." Throughout the inspection we saw staff using personal protective equipment (PPE) such as gloves and aprons to assist with infection control.

The registered manager and area manager both monitored staffing levels at the service. The area manager said, "We have a dependency tool in every care plan. That's reviewed every month by the registered manager, who sends it to me as part of a monthly report." The registered manager said, "We're recruiting at the moment as two (members of staff) left recently. We recruit 10% above the assessed dependency needs." Day staffing levels (during the week and at weekends) were two senior carers and seven carers working from 8am to 8pm. Night staffing levels were (during the week and at weekends) one supervisor and four carers working from 8pm to 8am. Rotas we reviewed confirmed this. The registered provider had three other services in the region and these were used to provide staff to cover absences. The area manager said, "We use agency at a push but don't like to as they don't know the residents." Housekeeping and kitchen staff completed the same training as care staff, so were able to provide care support in emergency situations.

Staff told us enough staff were deployed to support people safely. One member of staff told us, "I think we've enough staff. We lost a couple recently but are recruiting. Staff are really good at helping out. Our priority is the residents." Another said, "I think we have enough staff. Staff are really good at getting the job done." A third told us, "There is enough staff, I think there is anyway but we have had a recent high turnover with quite a few that have left so some of us have been doing extra hours but we always have cover."

Throughout the inspection we saw that people's requests for support were dealt with quickly, and staff had time to walk around the service making general checks on people.

The registered provider's recruitment procedures minimised the risks of unsuitable staff being employed. Applicants completed an application form requiring them to detail their employment history and provide details of two referees. Notes of applicants interviews showed they were asked a series of care scenario questions, such as, 'What would you do if there was a safeguarding in the home?' Applicants were required to provide proof of their identify and address. Written references were sought and Disclosure and Barring Service (DBS) checks carried out before applicants were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. One member of staff told us about their experience of the recruitment process, saying, "I had a DBS done when I came here, and references."

Staff understood safeguarding issues and procedures were in place to minimise the risk of abuse occurring. There was a safeguarding policy in place, though we noted this was a policy generic to all of the registered provider's services that had not been customised to Beeches Care Home (by, for example, including the registered manager's details in it). Where concerns had been raised we saw they had been referred to the relevant safeguarding department for investigation. Staff were able to describe the types of abuse that can occur in care settings and felt confident to report any concerns they had. Staff also confirmed there was a whistleblowing policy in place. Whistleblowing is where an employee reports misconduct by another employee or their employer. One member of staff told us, "We have a whistleblowing policy. We have training on it. I'd use it. Staff have used it in the past."

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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection 18 people were subject to DoLS authorisations, all without conditions. Clear records of these were kept, which contained evidence of the involvement of external professionals and people's families.

Where people lacked the mental capacity to make decisions about aspects of their care staff were guided by the principles of the MCA to make decisions in the person's best interest. Care or treatment decisions covered a wide range of decisions from every day choices about what to eat, drink or wear, to life changing choices about serious medical treatment or where to live. For those people that did not always have capacity, mental capacity assessments and best interest decisions had been completed for them. These were decision specific and stated that the assessment covered, "decision to live in home, able to leave home, danger and hazards in home". Records of best interest decisions showed involvement from people's family and staff. This meant people's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

Some people had made advanced decisions on receiving care and treatment and do not attempt cardio-pulmonary resuscitation (DNACPR) orders had been completed. The correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Consent to care and treatment records were signed by people where they were able. If people were unable to sign, a relative or representative had signed for them. We saw from a person's records that their relative held a lasting power of attorney. However, we were unsure as to whether this related to health and welfare interests and/or financial affairs, as there was no copy of these legal documents held within the person's care records. This meant staff may not be aware that the relative had this power. The registered manager said they would ensure the authorisation was added to the care plan.

People were supported to maintain a healthy diet, though records to support this were not always detailed. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. People's weights were monitored in accordance with the

frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals, such as GPs, dieticians and speech and language therapists, for advice and guidance to help identify the cause. We did not see the use of choking risk assessments to identify if people were at specific risk of eating and drinking.

Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the food a person was taking each day, however portion sizes were not included. Fluid intake charts recorded the fluid a person was taking each day, however fluid intake goals and totals were not recorded. Charts were usually fully completed, though we did see some gaps. For example, one person had no food or fluid intake recorded on 28 April 2016 and there was no record of why. We also saw that the care plan for one person who had diabetes was limited and simply stated, 'ensure a healthy diabetic diet.' We spoke with the registered manager about this, who agreed the care plan needed more detail and said this would be done immediately.

The dining rooms were pleasantly presented, with table cloths, cutlery and condiments. There were small menus on tables, but we were told people were asked what they would like to eat in advance of meals. Everyone had chosen shepherd's pie on the day of our inspection. We did not see people being asked if they were still happy with their choice, though one person did say they had changed their mind and was offered an alternative. We asked the registered manager if this arrangement was suitable for people living with a dementia who may have forgotten their choice, and were told that dementia friendly menus had been purchased and should have been used at lunchtime.

Some people chose to eat in their rooms. Meals were served from a central trolley, which was pushed around the building to serve people in their rooms before being taken to the dining room. We were told that the first service alternated between the dining room and people in their rooms on a daily basis so no one was consistently waiting too long for their meals, but we noted this lead to a delay in most people receiving their lunch. One person told us, "They serve the big lounge first, we are always last." Another person said, "The food is good. You sometimes have to wait if you miss a meal but you always get it. I don't know what it is today but it will be good." Another told us, "Food is good. We have set meal times but if you miss that you get fed. No problems. If I wanted something else (staff) would get it."

Staff said they received the training needed to support people effectively. Staff received mandatory training in areas including manual handling, safeguarding, health and safety, infection control, pressure ulcer care, fire training, the Mental Capacity Act 2005 and nutrition. Mandatory training is training the provider thinks is necessary to support people safely. Training was regularly refreshed to ensure it reflected the latest best practice. The registered manager and area manager used a training chart to monitor rates of completion of training. This showed that in 2016 most staff had either completed mandatory or refresher training or plans were in place to ensure this. The registered manager said, "Some training is external, some in-house. For example, [the local authority] do good first aid training." The area manager said, "Most training is in-house. If we required some specialist training we would get someone in to do it." All staff received the same mandatory training, which meant housekeeping and kitchen staff were trained to provide personal care and support in emergency situations.

Newly recruited staff completed induction training. This covered areas including the service's policies and procedures, health and safety and delivering care. Staff records contained certificates confirming when induction training had been completed. Staff we spoke with confirmed they had completed induction training.

Staff spoke positively about the training they received. One member of staff said, "I have had plenty of training, and have some in arranged for [named date]. We do the training here and we get paid to come in and do it. If there was specialist training we needed [the registered provider] would automatically put you through any training you needed." A member of the kitchen staff said, "We do most of the same training. It's good as we feel involved in how the home is run."

Staff felt supported by regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Records confirmed that staff were able to raise issues at supervision and appraisal meetings, which were used to discuss any training or support needs staff had. At appraisals staff discussed their achievements over the last year and their support needs for the next 12 months. One member of staff told us, "When I do supervisions I discuss training, goals and any actions needed." Another told us, "We discuss relevant policies for that month."

People were supported to access external professionals to maintain and promote their health. Care records showed details of appointments with and visits by healthcare and social professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), district nurse teams, podiatry, dieticians, speech and language therapists, DoLS reviewers, mental health teams and dentists. A GP who was visiting the service during our inspection said, "There is an excellent line of communication. They are very good at reporting concerns and getting other experts involved." This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure the individual needs of the people were met.

Good

Is the service caring?

Our findings

People were treated with dignity and respect. Staff were polite and courteous when speaking with people, whilst at the same time being open and friendly. Where people requested assistance we saw staff approach them and ask discreetly how they could help, or move them to a quieter part of the building to have a private conversation. Staff knocked on people's doors and waited for permission before entering their rooms. Where staff supported people we saw them asking for permission and working at people's own pace.

Staff described how they protected people's dignity while assisting with personal care. One member of staff told us, "We always maintain dignity. For example, if someone wants [help with personal care] we take them to their room and we speak quietly and ask for permission." Another told us, "We cover people up to protect their dignity, close doors and curtains. We make sure people are comfortable at all times."

People and their relatives spoke positively about the care they received. One person told us, "The staff are really good." Another said, "I can't fault them in here. It's really good" and "Nothing is too much trouble." Another said, "The staff are great. They work so hard and do anything for you" and "Staff are always there if you want them." A relative we spoke with said, "You won't find any problems here. It's wonderful."

Throughout the inspection we saw many examples of kind and friendly interactions between people and staff. In one case, a member of staff offered kind reassurance to a person who was living with a dementia that they were safe and would be helped with something they were trying to do. This helped to reassure the person and we saw them smiling in response to the member of staff. In another case, we saw a member of staff having a discussion with a person and their relatives about the person's plans for that week. The person clearly enjoyed the conversation. Staff tailored their communication approach to ensure people could understand them. For example, we saw staff speaking slowly, loudly and clearly to a person who had hearing difficulties. One person told us, "We are like a little family. I have some friends in here which is nice. We all look after each other."

Staff said they enjoyed spending quality time with people and getting to know them. One member of staff told us, "I like talking with people about the photographs in their rooms, about their families. I like to have one-to-one time with people and I think we can here. I think one-to-one time is very important. Some residents can be quite alone, and one-to-one time can make a real difference." Another said, "I like the interactions you get to have. You can speak to people and have a conversation."

Staff also said they promoted people's independence whilst ensuring they received the care and support they needed. One member of staff said, "If they can do anything themselves we allow them to. We do that to promote independence." Another told us, "We encourage people to do as much as possible. We take things in slow steps when helping."

At the time of the inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager understood how to support people in

accessing advocacy services and when this might be appropriate, giving the example of one person who might need an advocate soon.

No one at the service was receiving end of life care, but procedures were in place to arrange this where appropriate.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the service. Care plans were then developed to meet people's daily needs on the basis of their assessed preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans were developed in areas such as mobility, personal hygiene, skin integrity, continence, mobility and nutrition to ensure people's needs were met and contained evidence of people's preferences. For example, one plan detailed the kinds of activities the person enjoyed and how they could be best supported to engage with them. Another person had a care plan for a wound they had suffered. The care plan was clear, detailed and evidenced the healing progress being made.

However, some of the plans we saw contained limited or no detail on how to meet people's needs and preferences. For example, one person was living with Chronic Obstructive Airways Disease (COPD). Their care plan stated said that staff should 'monitor' their oxygen therapy 'at all times' and 'report any concerns', but contained limited guidance for staff on the specific dose and time frame that the person needed oxygen therapy and how often checks should be made. We asked the registered manager about this and they said the care plan would be updated to include all necessary information. Another person's care plan contained limited information on how staff could promote effective communication when the person was confused. The registered manager said this would be updated.

Handover records showed that people's daily care was communicated when staff changed duty at the beginning and end of each shift. We saw these covered areas including how the person had slept, their activities that day and any visits received by external professionals. Information about people's health, moods, behaviour and appetites were shared, which meant staff were aware of the current health and well-being of people.

The service employed an activities co-ordinator, who assisted people to access activities based upon their needs and preferences. Each person had an 'activities assessment', setting out their preferences and how they could be supported to participate. For example, one person's assessment identified their interests as 'going out and shopping and dogs' and said, 'joins in most activities if asked.' The activities co-ordinator also kept a record of attendance at activities, which they used to see which were popular and to ensure that everyone had access to some form of activity. We did note there were no specific activities for people living with a dementia.

We saw evidence of activities including film days, bingo, parties for national events and physical exercises. There was also an enclosed garden that was used for barbecues and that people could spend time in. One person told us, "We go outside in the garden when the weather is better. It hasn't been too good lately though so I haven't been out there for a while." Another said, "There's enough to do." The activities co-ordinator was on leave during our inspection, and during their absence we noted there was limited activity provision at the service. One member of staff said, "When [the activities co-ordinator] is not here we will try and do things."

There was a complaints policy in place, and where issues had been raised these had been investigated and the outcomes communicated to the people involved. The last recorded complaint was in February 2015.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and registered provider carried out a range of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

Quality assurance audits were carried out in areas including care plans, nutrition, infection control, activities, falls and medicines. Where issues had been identified by audits we saw that this usually led to remedial action. For example, 13 care plans were audited in March 2016 and actions for remedial action included, 'care plans and risk assessments need signing, falls and evacuation care plans need updating, eating/drinking/elimination/mobilising/personal dressing/social needs and sleeping care plans need updating.' We saw that the actions had been signed off as completed. A health and safety audit from April 2016 led to an action plan being produced which the registered manager was working through.

However, we also saw that audits had not always led to necessary remedial action. For example, a nutrition audit in January 2016 considered whether people living with a dementia were offered a visual choice of meal. Remedial action was logged as, 'yes, we also use flash cards.' People living with a dementia were not offered a visual choice or shown flash card menus during the inspection. Medicines audits were completed however they lacked detail. General storage audits did not detail which floor they had been completed on and any required or completed actions to make improvements were not recorded.

Staff told us about the culture and values of the service. One member of staff said, "A lot of people describe it as having a homely atmosphere. That's what I like to think of it as. There's always laughter from staff and residents, which I think is a good thing." Another told us, "A very friendly home. Carers and residents are like family here. It is a really nice place. You get good vibes when you walk in." The registered manager said, "If I am interviewing someone (for a job) I will always tell them this is the residents' home treat it like you would your parents' or nana's. This is everyone's nana or mam. Treat them like your own."

Staff felt supported by the registered manager, who they said was approachable and would help them resolve any issues they had. One member of staff told us, "[The registered manager] is stern and strict but lovely. So approachable, but gets things done. [The registered manager] has rules and they get followed but is lovely. I like [the registered manager] as they will deal with any problems you have." Another said, "[The registered manager] is lovely. We have a good working relationship. [The registered manager] is very fair, I think, and you can approach them with anything you need." A third member of staff told us, "I like [the registered manager]. Very approachable."

Health and safety meetings took place to share information and allow staff to raise any concerns they had. Staff were required to sign the minutes of such meetings to confirm they had attended or had familiarised themselves with what was discussed. One member of staff said, "We have staff meetings. Sometimes if [the registered manager] has concerns or other times if staff themselves have concerns. [The registered manager] always involves staff and ask for feedback, but also gives us an opportunity for a private word."

Feedback was sought from people using the service and staff through annual questionnaires. A summary had been produced of the most recent survey of people who used the service, to inform them the results were 'very good' and the home was 'good in care, food, activities and excellent in housekeeping'. It stated that the aim was 'to be excellent in all areas' but there was no information as to how this was to be achieved.

The registered manager told us about the links the service had with the local community. They said, "We have links with [named local school]. They come in and do Christmas Carols and at Easter. They invited us to their nativity play. We have links with [named local churches] and they come in and do Holy Communion. We have links with Macmillan Cancer Research. We do sponsorship and fundraising."

The registered manager understood their role and responsibilities and the types of notifications that should be made to the Commission.

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 RA Regulations 2014 Safe care and treatment Controlled drugs stocks were not always accurately recorded. Storage temperatures were not accurately recorded, or recorded at all. Care plans were not person centred for medicines administration. Medicines audits were completed however they lacked detail. 'As required' (PRN) medicine care plans were not always sufficiently detailed. Self-administration risk assessments were not in place.. The frequency of medicine administration was not always safely managed. Regulation 12(2)(g).