Care Quality Commission

Life Care Corporation Limited

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Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection which took place on 23 June 2015. Life Care Corporation Limited is a care home for older people and is registered to provide care for up to 41 older people.

The service is provided in a large detached building which is located near to public transport. The home provides a range of services for older people, some of whom may be living with dementia. The home is divided into two units arranged over two floors.

The home is managed by a 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.

The home had a range of methods to ensure that people were kept as safe as possible. Care workers were trained in and understood how to protect people in their care from harm or abuse. People told us they felt safe and could talk to staff and the manager about any concerns they had.

Summary of findings

Individual and general risks to people were identified and were generally managed appropriately. However, risk assessment records were not easily accessible and were not always updated when changes occurred. Care records were in various stages of transition to a new format. There were inconsistencies in the recording of people's care needs. Regular members of the staff team had knowledge of the people and their needs. However, people could be put at risk of being provided with inappropriate care because staff may not be sure of what was required.

People's medicines were administered safely. Staff were appropriately trained and their competence was assessed. Medicines prescribed to be taken as and when necessary (PRN) for the management of behaviour Was not always supported by clear guidelines to ensure that they were given appropriately.

The home had a robust recruitment process to ensure that the staff they employed were suitable and safe to work there. The service had a core of stable staff who communicated well with each other and had built strong relationships with the people living in the home. Staff were praised by people and their relatives for being "kind and thoughtful", "marvellous" and one person said the "staff here are brilliant". There were sufficient staff on duty to support people appropriately. However, staff were not always well organised or deployed in the most efficient ways.

The service understood the relevance of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). Appropriate actions were taken in relation to people's capacity to consent to a range of decisions relevant to the particular individual. Staff had received MCA training. People's capacity to make decisions for themselves and providing people with as much choice as possible were subjects that were discussed in team meetings. The MCA legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. Deprivation of Liberty Safeguards (DoLs) provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager, senior staff and care staff demonstrated their understanding of consent, mental capacity and DoLS.

People were given the opportunity to participate in activities and this was a developing area now that a full time activities organiser had been appointed. People were treated with dignity and respect at all times. They and their relatives were invited to be involved in many aspects of the running the home.

The house was well kept and repairs were dealt with promptly. Cleanliness was of a good standard and infection control procedures were adhered to. It was noted that some cupboards that should be locked had been left open. This could present a risk to people living in the home.

People and staff told us the registered manager was very approachable and could be relied upon to respond appropriately to requests or concerns. It was clear that she was highly regarded by the provider, staff, people and their relatives. People, their relatives and staff told that there had been considerable improvements made in the home over the previous seven months.

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

People were not always kept safe.

Inconsistencies in peoples' documentation had the potential to put them at risk as staff might not have the correct information to know how to support them appropriately.

Staff knew how to protect people from abuse and people felt safe living there.

Any health and safety or individual risks were identified but written risk assessments were not always up to date, reviewed regularly or easily accessible.

Is the service effective?

Good

The service was effective.

People's mental capacity to make decisions and deprivation of liberty issues were understood and documented.

Staff understood and were aware of the need to obtain peoples consent.

The change to food provision whilst receiving different reviews from people was more nutritionally balanced.

Is the service caring?

Good

The service was caring.

Staff responded to people with patience and understanding.

Staff treated people with respect and dignity.

Staff were highly regarded by people and their relatives.

Is the service responsive?

Requires improvement

The service was not always responsive.

It was not clear what action had been taken in response to concerns and complaints about the service.

People were being offered more daily activities which helped them to enjoy their life.

People told us that their needs were met but staff did not always respond to requests in a timely manner.

Is the service well-led?

Requires improvement

The service was not always well-led.

The manager provided a detailed action plan addressing all the issues raised at the inspection very promptly.

Summary of findings

Records were not always up to date and information was hard to find in people's personal files.

The manager had introduced a range of improvements to enhance the care provided.

The manager did not always delegate appropriate tasks to senior staff.

The manager was highly regarding by people, the staff and health care professionals.

Life Care Corporation Limited

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 inspection took place on 23 June 2015 and was unannounced. The inspection was undertaken by three inspectors. We reviewed information provided in the Provider Information Return (PIR) and from notifications made to CQC by the service. A notification is information about important events which the service is required to tell us about by law. The PIR is a form the provider completes which details information about the service and includes the areas where it performs well and identifies when and where improvements are needed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition, less formal observation of staff conduct and interaction with people took place throughout the duration of the visit. We looked at eight care plans, daily notes and other documentation relating to people who use the service such as medication records. In addition, we looked at auditing tools and reports, health and safety documentation and a sample of staff records.

We spoke with the provider, registered manager and four staff individually. We had contact with a range of people associated with the service including people using the service and their relatives. We spoke with six relatives of people, of which four were contacted by telephone following the visit. Ten people using the service were spoken to individually to ascertain their views and experiences of living in the home.

A community nurse manager and two health care professionals provided feedback about their dealings with the service. We spoke directly with three local authority representatives including a quality manager, safeguarding manager and a best interests assessor.

Requires improvement

Is the service safe?

Our findings

People were kept safe from any form of abuse or poor practice. People told us they felt, ''safe'' or ''very safe'' in the home. A relative commented that she was very happy that her husband was kept safe in the home by the staff. Health care professionals told us, "People have seemed safe and well treated", "I have not noted any concerns, resident safety does appear to be a priority for Life Care". "While present at Life Care I observed staff dealing with an ant problem in one of the bedrooms, which they dealt with appropriately and considered resident safety when undertaken".

Detailed individual risk assessments were available in some care plans, they clearly instructed staff how to give safe care to people and minimise any risk, as far as possible. These included areas such as skin integrity and nutrition. However, some care plans did not contain detailed risk assessments and there was not enough information to ensure staff were able to minimise identified risks. The transition plan identified the risks however, did not illustrate how these should be managed. This was discussed with the registered manager, who advised this would be dealt with immediately. A number of different documents had been removed due to restructuring of files. This did leave residents vulnerable, as documentation on how to support and manage risk was not contained on file, this was particularly relevant as one new staff had been appointed recently.

Following the inspection the registered manager provided an action plan to address the issues raised in the inspection. On the 29 June the registered manager confirmed in writing that all temporary care plans now had full and detailed risk assessments attached to them.

Incidents reports were not appropriately recorded within the files. New and old file structures contained limited information; for example care plans and risk assessments were sectioned into various domains such as communication, health, mobility, mental capacity and personal care. The files then contained a section at the back for daily records. Some residents files did not contain any assessments or incident details. Some incident recording sheets had not been transferred to the central incident report record nor had they been signed by the registered manager as reviewed.

Safeguarding referrals were made to the appropriate authorities as necessary. Staff were able to describe the signs and symptoms of abuse and the action they needed to take if a suspicion or allegation of abuse was made. They were confident that the registered manager would take any necessary action to prevent any type of abuse. The home had a whistleblowing policy which staff were aware of. Staff understood their responsibilities with regard to keeping people safe and were aware of the interagency policy of safeguarding vulnerable adults.

The service provided enough staff to ensure people were given safe care, at all times. The registered manager advised that no agency staff are used within the service. Any staff sickness is managed within the existing staff team. This allows familiarisation with the residents and continuity of their care. However, staff were not always effectively deployed. People told us there were, ''usually'' staff around to help them. They said that there were times when there were no staff in the lounge and they said that the registered manager told them there should always be someone there. They said that when they rung for help you, ''usually'' didn't have to wait too long. During the inspection staff were not always organised. In the sitting/dining area there were, at times four or five staff attempting to do the same tasks and then only one when more were needed. However, those people who needed assistance to eat were generally well supported.

The service took the safety of people, staff and visitors seriously. Generic health and safety risk assessments were in place to make sure staff worked in as safe a way as possible. Generic risk assessments included uncovered radiators, work space layout and fall hazards. Risk management plans instructed staff how to work in a way that minimised risk to themselves, the people who live in the home and others. All health and safety risk assessments had been reviewed on 11 November 2014.

Health and safety maintenance checks such as boilers and fire alarm systems were completed at the recommended intervals. The Health and Safety records were all up to date. The service provided staff with information to enable them to effect an emergency evacuation, as safely as possible. An annual health and safety review had been completed on 13 February 2015.

All equipment inspected was appropriately checked, and safe for use, for example hoists did not need inspection until later in the year. The registered manager advised that

Requires improvement

Is the service safe?

these are inspected by the providers of the equipment annually. The premises were kept clean and tidy however, some corridors did store extra equipment, for example one wheelchair and two spare seat cushions were placed outside the laundry sorting room in the West Wing which could have caused a hazard to people. The bedrooms were kept clutter free. Where residents chose to have a high number of items in their rooms, these were managed through open dialogue and persuading people to keep items close to the perimeter of the room.

During the site inspection there were a number of cupboards left open that contained potentially dangerous and harmful items. For example the lift mechanism cupboard, with a keep shut sticker on the door was left open on the first floor, a cupboard containing hand washes and shampoos was left unlocked, the fuse board and meter cupboard which contained loose cables was also left unlocked. All of these cupboards were accessible to residents. After the inspection the registered manager sent written confirmation that all staff had been reminded to ensure that cupboards which could present a risk to people were kept locked.

Three staff files were seen for the latest care staff recruits. The files illustrated that a full employment history explaining any gaps was obtained. Appropriate references were obtained. There was a note on one file that the recent professional reference could not be obtained due to the manager leaving their post. The last place of employment had gone into administration. An application for a Disclosure and Barring Service (DBS) for each person had been made. Training had commenced prior to the member of staff starting work with residents and beginning formal induction.

People were helped to take their medicines safely. The service used a monitored dosage system (MDS) to assist staff to administer medicines as safely as possible. The service had recently introduced an MDS system provided by a different pharmacy. Staff told us they liked the new system which was simpler to use with less likelihood of making errors. The system used pictures, symbols and tick lists to simplify instructions and records. Medicines were supplied monthly and any changes in prescriptions were sent to the pharmacy by the GP's surgery. The pharmacy were planning to audit the system every three months. The medication administration records (MAR) were accurate.

Only staff who were trained in medication administration gave medicines. The staff member giving medicine on the day of the inspection, fully understood the medicine administration, ordering and safe storage systems. Written guidelines for when people should be given medicines prescribed to be taken as necessary (PRN) were provided. The guidelines for medicines to be given PRN for pain relief were adequate but those to be given to support people to manage their behaviour did not contain enough detail to ensure they were given in a consistent way. An example of instructions for the use of PRN medicine included give when, ''agitated''. There was no description of what agitated meant for the individual or any description of de-escalation techniques to use prior to using PRN medication. Staff told us the medicine had not been used for over three months and only senior staff who knew the individual well administered the medicine. The senior staff member told us that the service were not using any controlled drugs or giving covert medication, at this time.

The home was clean and tidy throughout. The senior housekeeper told us that everything had improved since the registered manager had returned from extended leave at the end of last year. They were now issued with better quality cleaning products and there were cleaning schedules and task sheets which had to be filled in daily. There was a deep cleaning rota for bedrooms. The whole process was much better organised and clearer for staff who were now working better together as a team. Relatives told us that the home was much cleaner than it had been previously. One relative did say that there was sometimes a lack of toilet rolls in the toilet. Health care professionals told us, "Cleanliness seems to be of a good standard, it would benefit from hand towels", and " The home seems clean and hygienic: lack of hand towels can be a problem".

Good

Is the service effective?

Our findings

People were cared for by staff who were appropriately trained and supported. Staff files illustrated that all mandatory training had been completed and was in date, with specialist training offered as supplementary for example: dementia, equality diversity and inclusion and epilepsy. The training that was due to expire had been booked for example dignity in care. In addition, all staff had been booked on the Skills for Care Common Induction Standard, irrespective of when they commenced employment. Three of the 25 staff had achieved a qualification equivalent to NVQ (national vocational qualification) 2 or above and eight others had embarked on qualification courses. A personal development plan was written for staff as part of their annual appraisal and supervision cycle. Some specific training needs, such as spoken and written English, were identified at interview and noted as a condition of employment.

Staff told us that staffing generally and each shift were much better organised following the registered managers return from extended leave. This allowed more time to spend with residents. Staff were able to give a good account of their role and responsibilities. Some staff told us that they did get involved in assessment of needs and care planning whilst others said that they write daily care notes only. They described recent training undertaken in a range of topics including, safeguarding and dementia awareness. We were told that regular three monthly supervision had started since the registered manager had returned and she had also introduced group supervision which was described as very useful. All staff said that they were happy in their role. We observed a staff handover which contained clear updates about people and tasks were allocated to be completed by the afternoon shift. The home held monthly staff meetings. This was an effective way of communicating both residents' needs and establishing individual staff growth and development, and was reflective of the changes within the organisation (for instance introduction of new roles – team leaders).

All staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's ability to make decisions for themselves was noted on some care plans. These included capacity assessments and best interest decisions, as appropriate. Applications had been made for DoLS for a number of residents, however the relevant paperwork could not always be located to illustrate this in the resident's files. Mental capacity assessments were found to be written in some files on risk assessment documentation, this however was also correctly presented and evaluated on MCA (in house paperwork) for tasks such as personal care, clothes and choice. There was no paperwork in care plans with regard to 'lasting power of attorney'

The service had introduced ready to eat, nutritionally balanced, frozen main meals for people from a recognised provider. Until recently food was cooked from fresh within the premises by care staff. There were mixed views in response to the change in food. The service had organised taster sessions and meetings for people and their relatives to obtain their views about the new meals. Residents were asked if they liked the food, which had generated differences in opinion. Three people told us they preferred the fresh food they used to have, one person enjoyed the food and another provided their own food. Relatives overall thought the changes to the food was a good thing and one described the food as,"much nicer". Staff said the arrangements were much better and some people had been putting on weight since the change had been introduced. We were told that individual additional meals were kept in case someone did not like either choice on offer. In addition, salad vegetables and sandwich fillings were purchased separately. Pureed foods were subject to a separate order according to need. The four weekly rolling menu for both lunch and tea could be altered by the service according to the preferences of the people living in the home.

Most people were helped to eat and drink in the way described on individual care plans. The majority of staff sat with people to encourage them to eat and drink enough at the meal time. Staff were patient, positive and gentle when they encouraged people to eat. They successfully used discussion, humour and praise to persuade people to finish their meals. On one of the wings three residents did not wish to eat the food offered. Staff did not respond to their needs appropriately. For example, one resident who was being supported with food, repeatedly stated 'no', the staff member attempted to coax the resident into eating but when they didn't open their mouth in time, some of the food spilled on to the clothes protector. No alternative food

Good

Is the service effective?

was offered. One person was not assisted to eat although their care plan noted they needed assistance. The team leader said he only eats the meat at lunch time although this was not reflected in the meal time support plan.

There were fresh fruits, drinks and snacks available in the communal area which allowed for individual choice and independence. The drinks included hot drinks and juices. There was independent access to fruit and the availability of fruit was confirmed by some relatives. Individual preferences were included in the new care plans and were recorded in the kitchens on both wings. Two people did not like the recently introduced 'protected mealtimes' as they wanted to watch the TV when they were eating.

Food, fluid and weight records were kept for everyone who lives in the home. However, care plans did not include individual 'target' food or fluid intakes and did not describe when staff should alert senior staff to people when the generic 'target' of 1000 to 1400 millilitres was not achieved. The GP prescribed nutritional supplements, as necessary. The action taken by staff when a substantial weight loss had been noted was not always recorded. However, it was clear that there had been an amendment of the care plan to meet the changed needs. This area requires improvement due to the inconsistencies of information contained in some care plans documentation. The recording of all actions in response to changes in need such as contacting the GP were not always clear in care plans.

People told us they could see a doctor or nurse whenever they felt they needed one.

People were helped to seek advice from health care professionals and specialists, as necessary. Healthcare records were kept of referrals and consultations. The service sought assistance from the community mental health team, dieticians, district nurses, tissue viability nurses and other appropriate services. One healthcare professional told us that, "Staff are approachable, they do give updates on a client's presentation and any concerns. The staff refer me to speak to the manager regarding care issues". Another said, " There are always staff around to talk to me about residents and they seem thoughtful and interested and concerned. Health needs seem to have been addressed in a timely manner".

The service provided a clean and hygienic environment for people to live in. The home had made some significant improvements to the presentation of the environment over the last year. However, the restricted communal space had further limited the ability to differentiate room usage for example, one room was used as an: activities room; dining room; TV room; lounge; medication and storage trolley / room. The quiet room was used for this purpose as well as a family meeting room; cinema room; staff meeting and as a quiet room for people. We were advised by the Team Leader on shift that this room was kept locked preventing access, due to one of the resident's 'wandering' behaviour. This point was raised with the registered manager who advised this should not be the case, and would address this.

There were a large number of notices around the building which detracted from a homely feeling in the home. For example, there was a large notice in the east wing dining area which read, ''help yourself to snacks and drinks''. It was written in large letters in black ink rather than an attractive poster type style which may have enhanced the environment.

Each bedroom door had the room number and name of the resident written on it. These were not positioned at eye level neither were they personalised with photos or pictures of significance to the resident. Bedrooms were to a degree personalised. For example, one resident had brought a vast collection of his entertainment with him, further he had two budgies in his room, this allowed him to continue with his hobby (collection of entertainment). Different colours had been used to distinguish areas throughout the home. When asked not all staff understood the colour coding system. However, the registered manager and staff team were implementing the ideas from a recognised dementia care organisation to enhance the environment so that it becomes more dementia friendly.

We recommend that the provider review the training for staff to ensure that they are aware of the need to provide people with choices and to treat them with patience and respect at all times.

Good

Is the service caring?

Our findings

The majority of people told us they liked or, ‘‘didn’t mind’’ living in the home. One person said, ‘‘it’s good living here, I enjoy it’’. Another said, ‘‘it’s pleasant, I like living here’’.

People told us they were treated with dignity and respect. They described staff as, ‘‘kind’’. One person said staff, ‘‘treat me very well’’. Throughout our visit staff treated people with respect and preserved their dignity at all times. Staff offered people comfort and were very patient when meeting people’s needs. Residents spoken to were positive of the staff. One person stated “They look after us here. I have no complaints”. Another person said, “No complaints whatsoever. They’ve been quite nice to me.” Relatives were very complimentary about the staff. They were described as “marvellous”, “kind and thoughtful”, “staff here are brilliant”. One relative told us the “manager is the kingpin”. Things went down hill when “name” (manager) was off”. A health care professional told us “interaction between staff and residents that I have observed have been respectful when communicating with residents”. Another said, “I have been visiting Life Care since mid May and have found staff receptive and friendly”.

Relatives told us that there had been some next of kin meetings held where their views on the care provided in the home was sought. Relatives and people living in the home were encouraged to suggest improvements or to comment on any aspect of the running of the home. Food taster sessions had also been arranged in preparation for the change of food provision and mealtimes. Relatives said that the registered manager always asked them about how things were going whenever they visited the home. All the relatives we spoke with said that they felt included and involved with what was happening in the home.

Staff described food before it was placed in front of them, asked if they had finished before removing, and provided replacement drinks. Staff generally used a positive approach to meeting people’s needs. Staff were approachable, friendly often smiling at residents, even when the activity at hand was completing a task, for example administration of medicines. Staff described what they were doing and why and people were generally asked for their permission before care staff undertook any care or other activities. Throughout the inspection people were generally involved in whatever was going on and were communicative with each other. However, there were two occasions when a person did not want to wear a clothes protector and later they refused to eat. Staff did not provide this person with alternatives to the food offered and managed the refusals in a task focussed manner rather than being person focussed.

At the last inspection on 24t November 2014 there was a significant issue with the laundering of clothes which were often damaged in the process. Additionally, people’s own clothes were being lost and some people were wearing other residents clothes. At this inspection everyone was appropriately dressed and groomed. There was a dedicated laundry assistant who was particular about the care of peoples clothes and possessions. Most clothes were appropriately labelled and the laundry assistant knew who the owners were of items that were not. Relatives told us the, “previous clothes issue has now been sorted”. Another said their relative, “always looks smart”. One relative told us that pillows they had supplied went missing. They said there seemed to be a lack of pillows generally. The registered manager was made aware and undertook to address this issue without delay.

A staff member described how they were advocating on behalf of a person to try to improve their current lifestyle. One health care professional told us that staff, “do consider how to best support a (particular) client with eating and drinking and feeling comfortable”. It was evident from talking to staff and the registered manager and from general observations throughout the day that there was a commitment to improve the care provided in the service. The health care professional went on to say, ”Sometimes I have felt that some staff could be more interactive with residents instead of being busy writing care plans; I have told the manager this”.

Requires improvement

Is the service responsive?

Our findings

People told us that staff did not always respond quickly to their requests for help. They said that they felt that some staff ignored them when they called out. One person said, ‘‘some of them take no notice if you call them’’. One of six staff in one of the communal areas on the day of the inspection was not responsive to people. They ignored them when they called out and gave them their meals without any verbal interaction. Another staff member offered a visitor a drink but did not include the people they were sitting with in the offer. They had limited interaction with people and it was apparent from their facial expression that they did not like a particular person. However, other staff communicated with people at all times, were alert to their needs and responded quickly to meet their needs. Staff were able to interpret body language and people’s behaviour to identify when they needed help or attention.

Local authority representatives told us that they had found inconsistencies in the information contained within documentation designed to identify and meet peoples changing needs. They were not confident in the ability of the service to respond to people’s changing needs with the required urgency. However, other professionals were not in agreement with this view and our findings only partially supported the view held by the local authority. For example, one health care professional told us, “the manager and her team from my observations do make health referrals and appointments when required” and “I have liaised with the manager in regards to discussing clients, I have found her co-operative with working and proactively engages with providing person centred care”. Another senior nurse told us, “Management seem vigilant at referring residents for assessments as needed and incorporating the care into the care plans. The manager and staff have always seemed to work in the best interests of their residents”. Feedback from another local authority representative confirmed that the registered manager had requested occupational therapy assessments for two residents. The service had been waiting for a response from this local authority since 2 April 2015.

The service had employed an external consultant to review care planning records. Recommendations from their report were in the process of being implemented. At the time of the inspection there were three different types of records in place providing information about the care needs of people. Some records were in the original format, others had a temporary care plan which was very brief and a small number had been transferred into the new style. This provided clear sections for each aspect of an individual’s needs and their care management. This arrangement made review of the appropriateness of care planning information difficult. However, staff told us that the new care plans were better and it was easier to find relevant information. Staff described temporary plans as fit for purpose and contained relevant information.

People’s care plans were presented in various formats. Care planning was changing to a new system but the changeover had not been completed. Thirteen care plans remained in the ‘old’ format, eight were in the ‘interim’ format and four had been completed in the ‘new format’. Some people’s files contained more than one ‘format’. There was conflicting information in some files. For example one person’s ‘Do not attempt resuscitation’ form said they were ‘bed bound’ when elsewhere in the care plan it said they spent time in the lounge until after lunch. Another said the person was immobile in one part of the care plan and noted they were attempting to climb out of bed in another. Temporary care plans did not contain sufficient information to allow staff to understand how to support residents. For example, for one resident who has communication difficulty, staff are advised “...people need to materialise communication using visual aids”. No details are given of visual aids to be used. The process of upgrading all care plans to the new format was recognised as a priority and the registered manager confirmed that this work would be completed by 20 July.

One person had a one page transition plan in their folder. It contained an incomplete ’old’ care plan. There was insufficient information in place to ensure a responsive level of care. It was found that staff had knowledge about how one person struggled with mobility. This person takes meals in their own room. However, conflicting information relating to this person was found in the care plan and the individual support guidance at mealtimes. The care plan clearly identified how the person could only take a few steps with a zimmer frame. It did not state where the resident preferred to eat, that was with other residents in the dining room, conservatory or independently in their bedroom. The individual support at mealtimes stated this resident needed assistance with the zimmer frame to get to the dining table. This was raised with the registered

Requires improvement

Is the service responsive?

manager and the provider. The provider felt that staff knew the dining table was referring to the bed table in the person's room, and did not actually mean the dining table located on the ground floor. The registered manager accepted the need for correct details being written in the care plan so as to avoid potential confusion.

People told us that they had activities to participate in, if they wanted to. They said the variety of activities had increased lately and they can now go out if they wish to. Two people said they didn't want to go out or do any activities with others. They preferred to do their own activities and told us they weren't made to participate if they didn't want to. The activities co-ordinator had not been in post long. They were responsive to people and treated people with great respect. They had been completing some life story work with people and used this information as a basis to provide appropriate activities for individuals. Activities included sing-alongs, gardening, balloon volleyball, reminiscence and outings. People had an individual record of any activities they participated in. This noted people's enjoyment of the activity and if it could be pursued in the future. One relative told us they, "had a singer last week. My husband had a glass of stout which he enjoyed and was smiling and singing along". Another relative told us, "Mum cannot go out on outings due to her legs".

People told us they knew they could complain to the staff or the registered manager if they were unhappy about something. One person told us they had made numerous complaints which were always listened to and acted upon. A relative told us that they had raised issues which the registered manager had addressed quickly. The service did not specifically identify complaints. They were categorised as either safeguarding issues or service deficiencies. We advised that any 'service deficiency' identified by someone other than the staff team were complaints. There had been nine complaints recorded as safeguarding or deficiencies since January 2015. It was clear that action had been taken as a result of these 'complaints' but the outcomes had not been recorded clearly by the service. The registered manager provided written confirmation after the inspection that a central complaints log had been introduced which would record action taken and the outcome of all complaints.

Some communal rooms were not personalised or decorated in a homely manner. On one wing no personal photos or artefacts were noticed. Chairs outlined the perimeters of the room, reflecting a clinic setting. The fact that communal rooms served multi functions made the identification of the rooms usage difficult. However, peoples' bedrooms were decorated with items that had specific significance to them, many of which contained photos of family members, personal furniture and a decorated style that reflected their own specific needs and tastes. This, therefore met their individuality and choice and was reflective of their personal preferences. We noted that one door providing access to the garden was locked. The registered manager told us that this should not be the case and undertook to ensure people could access outdoor space when appropriate and that garden furniture would be made available from storage.

Requires improvement

Is the service well-led?

Our findings

The service had introduced team leaders to the management structure. There was a team leader for each side of the service which was designed to develop leadership within each wing and take some of the current responsibility from the registered manager. The management team were described as very approachable and supportive by people, their relatives and staff. There had been many improvements introduced by the registered manager over the last seven months since her return from extended leave. Staff felt much happier in their roles and understood their responsibilities more clearly. It was noted that the Statement of Purpose for the service would need to be updated to reflect the changes to the management structure.

The service had a culture of openness. This was reflected in meetings taking place with the provider and the relatives of people in order to seek their views. These were planned to take place frequently however, the provider advised that they were facing problems with arranging a meeting at a time convenient for all. Staff told us that they felt supported by the management team and they were approachable with regard to any issues or concerns. Health care professionals told us that the registered manager and staff were approachable, knowledgeable and eager to improve the service for the benefit of the people they cared for. The service worked closely with the local authority and other professionals to ensure they improved the care they offered to people.

The registered manager undertook quality audits which covered a wide range of areas including medication, infection control, recruitment and staffing, staff training, social activities and meals and nutrition. Any areas found to require improvements would lead to the formulation of a non conformity/deficiency report which included the actions required to secure improvement together with timescales for completion. A business development plan for the service had been introduced which outlined areas that had been improved upon and contained plans for developing the service in the future. An environmental assessment tool had been introduced in order to identify maintenance issues and general improvements required to the fabric of the building and the environment overall.

The registered manager had introduced a tool for the observation of care practice. This was undertaken in five to ten minute periods and was designed to provide staff with feedback on their practice and allow them to reflect on how they engaged with people and supported them. Staff supervision and annual appraisals had been reintroduced since the registered managers return and together with group supervision were being used to support staff and to drive improvements in people's care.

The service had obtained guidance and advice from the Kings Fund (an organisation specialising in dementia care) in documentation entitled 'Is your care home dementia friendly'. They were also working with the local Care Home Support Team to improve the care of people with dementia. One of their staff told us, "I would like to see more investment in the staff, and more activities in the dementia unit to provide a stimulating and homely environment. I understand from talking to 'manager' she has discussed with the home owner, putting into place a summer house which will have reminiscence activities'. Some of the initiatives designed to support people with dementia were not fully understood by all staff.

Records held with regard to the safe running of the service were generally well kept. However, the three stages of care plans being held in the service had created some discrepancies and ambiguities. There was also some confusion about how to keep particular records such as complaints. Not all records were cross referenced and some were difficult to follow and outcomes and actions taken were not easily accessible.

The registered manager was not routinely delegating tasks, which meant that often urgent pieces of work were left outstanding such as upgrading the care plan documentation. In addition, details were omitted from documents such as responses to complaints. The registered manager undertook the majority of the contact with external agencies including liaising with GP's and other health care professionals when required on behalf of people in her care. This not only produced a significant workload for the registered manager, but created obstacles to leading the service as well as might be achieved. However, the registered manager was highly regarded by people, their relatives and staff. Other professionals also found her to be responsive and well informed about people's needs. Once the necessary paperwork had been

Requires improvement

Is the service well-led?

upgraded and senior staff had been appropriately trained to take on some of the registered managers responsibilities we were confident that she would manage the service efficiently.