The Elms Residential Care Home Limited

The Elms Residential 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 June 2017, and was unannounced.

The Elms residential care home provides accommodation and personal care for up to 20 people. At the time of this inspection, there were 18 people using the service, some of whom were living with dementia.

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

During this inspection, we found that the registered provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People's health, safety and well-being were at risk because the registered manager and provider had failed to identify where safety was being compromised. Infection prevention and control procedures were ineffective and we found that hygiene in the service was poor. This included in areas where food was prepared. People's individual needs were not met by the adaptation, design or decoration of the service. This could compromise the ability of people living with dementia to move around independently. This constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager had failed to recognise potential harm to people using the service. Quality assurance and auditing mechanisms did not identify concerns we found during the inspection. This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were not sufficient in order to meet the needs of people and keep them safe at all times. This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from social isolation, particularly those people who were cared for in bed due to illness or frailty. The range of activities available were not always appropriate or stimulating for people living with dementia. Care plans did not always hold sufficient detail about people's life history or social needs. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. Best interests documentation was not always in place

where decisions had been made on behalf of people who lacked capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The dining experience was not conducive to an enjoyable mealtime and opportunity for social interactions, and we have made a recommendation about improving the dining experience for people.

Staff interacted with people in a kind and caring manner. However, we observed that at times people's dignity was compromised.

Appropriate arrangements were in place to ensure people's medicines were obtained, stored and administered safely.

People were referred to other health care professionals to maintain their health and well-being.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all risks were identified in relation to people's health and safety or appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Infection prevention and control procedures had failed to identify areas requiring improvement.

Staffing levels were not sufficient to ensure that they were meeting people's needs at all times.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

People received their medicines in a safe and timely manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted.

Improvements were needed in people's mealtime experience.

Staff received training relevant to their role and were encouraged to continue their learning.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed staff to be kind and caring when interacting with people. However, at times people's dignity was compromised.

People were supported to see their relatives and friends, and

spend time with them outside of the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activity provision was not at a level which would meet the individual and specialist needs of all people using the service.

Information recorded in people's care plans was not consistent across the service; some care plans provided a good level of detail about people's social care needs, whilst others held only brief information.

There was a complaints procedure in place. People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager and provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

Audits were completed to assess the quality of the service; however these had not been effective in identifying areas for improvement.

There was an open and transparent culture in the service. People, staff, and relatives felt able to voice their opinions and had confidence in the registered manager.

The Elms Residential 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.

The inspection took place on 6 June 2017, was unannounced and undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law.

During the inspection we spoke with six people living at the service, and four relatives. We spoke with the registered manager, four members of care and catering staff, and a distance learning tutor who was visiting the service to provide a supported learning session to staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed two staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

We found that people living in the service were at risk of harm. We found window restrictors were not in place on any of the windows above ground floor level. Some people were confused and not orientated to their surroundings, which put them at risk of falls from windows which could be fully opened. We also identified that wardrobes in people's bedrooms were unsteady and not secured to the wall, which posed an accident and injury risk. Floor coverings in some areas of the service were damaged and uneven in places, which posed a trip hazard. We discussed our concerns with the registered manager who took prompt action to ensure window restrictors were put in place, and secured all wardrobes to the walls.

We found one bed rail was loose and not properly secured to the bed. This posed a risk to the person of entrapment. There was a risk assessment in place; however, this had not been reviewed since January 2017. Monthly room checks were being undertaken by staff, but nobody had identified that the bed rail was unsafely fitted. Additionally the headboard was loose which also posed a risk. We brought this to the attention of the registered manager who promptly replaced the bed rail and secured the headboard.

We found the main kitchen area to be in a poor state of repair with a damaged worktop surface which meant it could not be cleaned properly or kept hygienic. Shelving was unclean with food debris, floors were unclean, and dried foods were not always dated or stored correctly. We were concerned about the risk to people's health so we contacted the environmental health department to report our concerns. The registered manager responded to our concerns by closing the kitchen immediately so they could undertake a deep clean.

Infection control procedures were not effective. Monthly audits were being completed by staff, however, they had been ineffective in identifying the issues we found requiring attention. For example, overflowing bins, dust and debris under chairs and mattresses, malodours in all areas of the service, and used continence aids left in bathrooms. We were also not confident that commodes were being sanitised thoroughly as the cleaning schedules were not consistently signed by staff to demonstrate this had been carried out. Bed sheets needed to be replaced as some had holes in them and were threadbare. We brought this to the attention of the registered manager who told us they would address the matter immediately, and carried out a full infection control audit of the service. They also spoke with and agreed for the local infection control team to visit the service.

All of the above constitutes a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback regarding the staffing levels. One person said, "You've only got to press this [alarm] and they are here." Another said, "They are understaffed, I can wait between 10 minutes and an hour but there is nothing they can do, it's a pity because they look after you well in here." Staff told us they felt that sometimes there were not sufficient staff. One staff member said, "Lunchtimes can be hectic, and the mornings are busy. Sometimes people have to wait, not too long, and we try and avoid this." Another said, "It depends on the situation. If we have a person who is on 'end of life' care, it can be harder as they need

more help from us."

Staff on duty reflected the levels reported on the rota, and the registered manager told us they also helped to provide care whenever needed. However, there was no system in place to ensure that staffing levels and skill mix were being reviewed continuously and adapted to respond to the changing needs and circumstances of people.

We observed at lunchtime there were not enough staff on duty to support people to eat their meals. Five people needed support to eat and it was clear there were not sufficient staff to assist people in a timely manner. One staff member was supporting two people to eat, and then attempted to support a third person. Another person constantly called 'please' to summon help with eating their meal, but no one was available until the registered manager came out to assist. We also observed that there was a lack of clear leadership between staff as to the tasks that needed to be completed, both during the lunchtime period and throughout the day. For example, at times we saw staff standing in the lounge area talking amongst themselves or watching the television. This time should have been spent interacting with people or talking with people who were cared for in their rooms.

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

Following the inspection, the registered manager told us they had increased staffing levels during the lunchtime period.

Risk assessments provided staff with guidance on how risks to people are minimised. Risk assessments were completed in relation to the risk of developing pressure ulcers, hydration and nutritional risks, falls, and mobility. However, we saw that the information held within moving and handling plans did not always provide adequate instruction which would ensure that people were moved safely and comfortably. One assessment said, "assistance required", and another, "needs guidance", but no other information to describe what assistance or guidance was needed so staff could ensure that people were moved correctly. Some people were having thickened fluids, which would indicate they were at risk of choking. There were no risk assessments in place which provided guidance such as how people were supported to eat or drink, their positioning, and how they showed that they were in discomfort. There was no guidance on the steps staff should take if the person began to choke.

The registered manager informed us following the inspection, that risk assessments had been put in place for all people at risk of choking.

Manual handling equipment, such as hoists, had been serviced, and there were systems in place to monitor the safety of water systems and the prevention of legionella bacteria.

Safe recruitment procedures were in place. We looked at the recruitment records of two staff, which showed appropriate background and identity checks had been carried out. These included contacting former employers for references and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about people who may be barred from working with vulnerable people.

People living in the service told us they felt safe. One person said, "I feel safer than at home, I kept falling over. I've got this [alarm] for when I want something or need to go to the toilet. Wherever I go I carry it." Another said, "It's a nice place, homely, all nice people here, nice girls [staff]." A relative told us, "I'm going on holiday and I couldn't go if I wasn't sure [relative] was safe, well [relative] wouldn't be here if I didn't feel that."

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "I did my safeguarding training last year. I know there are different types of abuse; physical, financial, verbal. I would report any concerns straight to [registered manager] or [provider]". Another said, "I would tell [registered manager] if I saw anything that wasn't right. Or the CQC [Care Quality Commission]."

Staff received training in medicines management, and annual competency checks were carried out. Systems were in place for managing medicines and people received their medicines in a timely manner. Medicines which needed to be taken on a particular day of the week were highlighted within medicine administration records (MAR) to ensure all staff were aware. Rotation charts were in place for people who had pain relief patches applied, to ensure the site of application was varied to avoid irritation of the skin. We saw that MAR's were accurately and consistently signed to show what medicines people had been given. Where people's medicines needed to be reviewed, for example, medicines for mental health, we saw that the appropriate professionals had been informed.

For people receiving medicines 'as required' there were detailed protocols in place for staff to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling. One person was prescribed medicines for agitation. There was guidance on interventions which may work to reduce the agitation before the medicines were considered. Having this in place reduced the risk of medicines being given when they may not be needed. We saw these medicines had not been required since they were prescribed, as strategies to calm the person had been successful.

Daily stock checks were completed by staff administering medicines. We saw that the registered manager also undertook random audits to check stock levels were correct. There were storage facilities for temperature sensitive medicines, and we saw that daily temperatures were being taken in the room that medicines were stored in. However, this had not been taken for the last three days, and we brought this to the attention of the registered manager.

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 decision 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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

People's records contained a 'mental capacity flow chart' which helped staff to asses a person's capacity to consent to decisions about their care that needed to be made. For example, the person's ability to consent to taking their medicines, and making appointments such as for the dentist or doctor. However, we found that formal documentation relating to best interests decisions was only available in one person's records.

One person had bed rails in place to keep them safe from falling out of bed. However, there was no information to demonstrate this was the least restrictive option to keep the person safe when they were in bed. Similarly, another person had a sensor mat (which alerts staff when the person attempts to move) in place, yet there were no best interests decisions documented in relation to these restrictions.

The registered manager told us that no applications for DoLS had been made for people currently living in the service, though consideration had been given to it. They explained that they always tried to ensure they maximised people's freedom in the least restrictive way. For example, they supported people to leave the service to go out with relatives or friends. Whilst this was good practice, there were people living with dementia, under constant supervision and unable to leave the service where DoLS applications had not been made. This meant that we could not be confident that the provider was aware of their duties and responsibilities under the deprivation of liberty safeguards and that people's human rights were respected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

We discussed situations where a DoLS would be appropriate, and the registered manager told us they would review all people living in the service, and would make the appropriate applications.

Staff demonstrated a good understanding of what the principles of MCA meant in practice. When we spoke to staff they showed us a pocket sized MCA flow chart which all staff carried. This provided a quick reference guide which staff could use if they were uncertain about a situation. One staff member said, "The [registered manager] drums it into us, enable people to make decisions, and if they refuse it is their choice." Another said, "We support people at their own pace. Make the task easy for them to understand and use gestures

and point at items. Then if they refuse, come back later. I always carry this card [MCA flowchart] it gives good guidance."

Staff had received training relevant to their role, such as first aid, infection control, dementia awareness, safeguarding, moving and handling, and mental capacity. Staff were also supported to undertake distance learning courses to increase their knowledge in areas such as dementia and food and nutrition, through the NCFE (Northern Council for Further Education). The NCFE provides learning linked to nationally recognised qualifications and awards. During the inspection we saw eight staff attending a learning session with the NCFE tutor. They told us, "The [staff] here are really interested in learning. They all do really well."

Staff told us they were encouraged to undertake relevant learning. One staff member told us, "I am currently studying for my level five leadership award." Another said, "I've just completed my NVQ [National Vocational Qualification] level two award." We saw from the staff training matrix that other staff in the service had also achieved or were undertaking NVQ's at different levels.

Staff new to the service completed an induction, which consisted of mandatory training and shadowing of more experienced staff. The registered manager told us that new staff would shadow between four and six shifts, depending on their level of experience. If new staff did not hold relevant qualifications in care, they were expected to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work, and we saw that currently two members of staff were studying for this award.

Staff received supervision sessions which provided staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "I had supervision last month, we talked about what my goals were, and any training needs I had." Another said, "I have supervision every couple of months. I asked for 'end of life' training, which has now been booked."

People were supported to eat sufficient amounts and maintain a balanced diet. This included keeping records of their food and fluid intake when there were risks. Some people needed support from staff to eat and drink. However, we did not observe people receiving adequate support with this during our inspection due to staff shortages.

The registered manager told us that 'comfort checks' were carried out on people every half hour where they were being cared for in bed. The checks included ensuring that people had drinks available to them. We saw that one person was being cared for in bed on the first floor, and the documentation showed that regular checks had been completed.

We received mixed feedback about the food. One person said, "I eat it all, some things I don't like but I persevere with it to keep up my energy. I've put on a bit of weight since I've been here. I've never been forced to eat anything, I've got no complaints." Another said, "The food, no, the cook is no good, you get enough but jelly and ice-cream, jelly and ice-cream, and so it goes on, they don't have nothing I particularly like." A third person told us, "If you don't like the meal they will get you something else. They cut up the food and feed the ones [people] that can't. I feed myself. I get plenty, If you want a biscuit they will get you one, if you want a cup of tea they will get it for you."

The dining area had recently been refurbished and had one large table in the middle of the room with seating for 10 people. There were two other smaller tables suitable for two diners. The tables were laid with a table cloth, cutlery, and condiments. We spoke to the cook who told us of people's dietary requirements. They were knowledgeable about how particular foods should be prepared, for example pureed food, and

how they communicated with the registered manager if people needed their meals to be fortified, due to weight loss. They said they spoke to each person at breakfast as to their choice of lunchtime meal, and that if someone requested something which wasn't on the menu, they would prepare this for them. The food looked appetising and varied, and portion sizes were prepared according to people's preference and appetite.

We observed the lunchtime meal. People were seated in the dining area prior to the food arriving. People were waiting at the table for 30 minutes before being served their food. Two people fell asleep before their food arrived. Three people said they had received the incorrect meal, and this was addressed by staff. We saw that one person would have benefitted from a plate guard to promote their independence, as it was clear they were struggling to place the food onto the cutlery. The mealtime experience for people was poor. The atmosphere was not relaxed or pleasurable for people, and did not take account of people's individual and specialist needs.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence or the Alzheimer's Society) to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. This included during the inspection where one person became unwell and an ambulance was called. People's records showed referrals were made to a range of professionals which included falls teams, dieticians, GP's, district nurses and opticians. One person said, "I go to the dentist in [local area]. I am due to go soon, they will help arrange for me to go. Apparently there is an optician who comes in". A relative told us, "[Registered manager] always tells me about appointments [relative] has. If [relative] is on anti-biotics or the doctor has been in they will tell me. They are quick to respond, [registered manager] is on the ball. They noticed a little lump on [relatives] eye, they got the doctor in and it turned out to be a cancerous lump."

Requires Improvement

Is the service caring?

Our findings

The provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture.

We observed some practices' that compromised people's dignity. For example, during lunch we saw that two people were being supported to eat by one carer, who then proceeded to support a third person. This did not ensure that each person was given the time and individual attention they needed. Another person was being supported to eat their meal but there was no interaction with the person, such as a description of what they were eating, or asking them if they were enjoying the food. We saw a staff member standing over another person as they supported them to eat, rather than sitting with them at eye level. We also observed that following lunch, several people had food on their clothes which were not changed promptly. This did not demonstrate a person centred and dignified approach.

We observed staff interacting with people during the day and also observed some areas of good practice. People appeared relaxed in the presence of staff and readily asked for support when they needed it. It was clear from listening to conversations between staff, people and visitors, that staff had a good knowledge of people living in the service. We saw kind interactions such as staff holding hands with people, and another rubbing the back of a person who was feeling unwell, who then was taken from the communal area to a private room to protect their privacy. At lunchtime a person began coughing, and the staff member reassured them using appropriate language and guidance.

People told us that staff were kind and caring. One person said, "They are very kind. I do whatever I can for myself. They come and check I am alright but they let me do what I want. Staff are not sloppy, it's a lovely place, they wait on you hand and foot. Anything you want they do for you, there isn't one of them I can't praise." Another said, "The girls [staff] are very nice, always jokey, keep you happy." A relative told us, "Very happy, they look after [relative] well. It's comfortable, friendly and like your own home. If it was me I'd be quite content to come in here, it's lovely. Other places might have all mod cons but they don't have the friendliness."

Formal 'residents meetings' did not take place in the service, and the registered manager told us that one to one discussions were undertaken with people to ensure their views were known. However, these discussions had not been documented, and therefore we were unable to review the effectiveness of this approach to ensure people had as much opportunity as possible to give their views. We did however see that monthly reviews were carried out on people's care plans, which were signed by people or their representatives. Aspects of care that people could still do for themselves were detailed, which demonstrated that people had been involved. For example, one record listed the things that made the person sad, the things that they could still achieve, such as putting their lipstick on, and how their condition affected them. This demonstrated that people's preferences, and things that were important to them were known.

We discussed with the registered manager the importance of gaining people's views routinely, and they told us that they had looked to improve this by putting a 'comments box' in the main reception. Two comments

had been recently posted which they had yet to review. They assured us they would look at improving their current systems to ensure people were routinely asked for their views.

Relatives and friends were able to visit as they wished, and there were no restrictions in place. One relative told us, "There is always staff to greet you and let you out. They have been very accommodating." Another said, "We [family] can visit when we want and nine times out of 10 I get offered a cup of tea." This meant that people were able to socialise with family and friends as they chose.

Requires Improvement

Is the service responsive?

Our findings

The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedroom. For example, bedroom doors had a small label to denote the person's name, which were barely legible. Some fixtures and fittings required replacement. For example, door handles were difficult to open. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment. We discussed the above with the registered manager and they told us that the provider was looking into making several changes to the building. This included naming the corridors after a street (chosen by people in the service) and changing all of the doors in the service.

There was not a dedicated activity co-ordinator working in the service. A member of staff worked in the service two days per week from 7am to 5pm, to take people out in the community if they wished. Outside of this arrangement, the expectation was that care staff supported people with activity in addition to their caring duties. People told us they wanted more to do. One person said, "I watch telly, read, we play cards and 'Connect four'. My [relative] takes me out. The staff have taken us to watch the truckers go past. I get bored sometimes when there are repeats on the telly." Another said, "I suppose more different things to do would be nice if it was offered."

We observed that for the majority of the day, most people were sat for periods of time with no stimulation, and were disengaged with their surroundings. Most people spent their day in the main lounge with the television on. Some people with more advanced dementia were not interested in the television; one repeatedly banged their hand on their leg, and another just fell asleep. Staff were seen to be available in the lounge area, but did not take the initiative to ask people if they would like to take part in an activity other than watching the television.

We were also concerned that people who did not wish to leave their rooms, or who were cared for in bed, were not receiving 'one to one' activity time with staff. One person we observed sitting in their room was asleep for the majority of their day. Improvements were required because the service had not considered the impact and risks to prevent social isolation. This is particularly important where people are developing, or living with dementia.

We observed the records kept of people's participation in activity. Several of the entries did not demonstrate that activity had been completed, and some had not been completed for several days, or in one case, months. Some contained information which did not demonstrate that meaningful activity had taken place. For example, one record stated, "watching TV in room", and another "Relative visited." Another record showed that staff had consistently recorded "one to one activity, enjoyed." There was no information on what the one to one activity involved, how long the activity was provided for, or the person's response to it.

We could therefore not be assured that there was sufficient activity provision across the service to meet people's individual and specialist needs.

People's care records included care plans which guided staff in the care that people required and preferred to meet their needs. This included, personal care, social and leisure, mental health, nutrition, continence, and eating and drinking. Where people were experiencing periods of distress or agitation, records guided staff in techniques which would help to calm the person and provide reassurance. However, the level of information recorded was not consistent across the service in some areas. For example, one person's record held no information about their social and leisure preferences, another held only limited information, and a third was much more detailed. Given the lack of activity taking place in the service, we felt this information was important to ensure that activity provision was meeting the individual needs of people. There was limited information about what brought wellbeing to people's lives, particularly for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness. Reference to people's life history was documented, but in some cases more detailed information was needed. By documenting a person's past life events and developing an individual biography of that person, it enables others to develop a better understanding of the person's past experiences.

All of the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not received any complaints, but had a complaints procedure in place should people want to raise concerns. We saw that details of how to complain were visible at the front entrance. We asked people if they knew how to complain. One person told us, "I'm quite happy here, I have no real complaints at all. If I did I could speak to the staff". A relative said, "I am not backward in coming forward so I would say something, if I wanted to talk about anything I would just go to the office."

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been in post since March 2014. They told us they did not have a formal deputy to help with the day to day running of the service, but was supported by two senior care staff who had taken on some additional management duties. They also told us that they were fully supported by the registered provider who they met with and spoke to on a regular basis to discuss what was happening in the service.

During the inspection the registered manager was open and transparent about how the service was run, and their failure to recognise obvious risks to people's safety, such as infection control risks and health and safety hazards in the home. Following the inspection both the registered manager and provider acted promptly to rectify immediate risks to people living in the service.

Systems for improving the service through auditing and monitoring had not been effective. Various aspects of the service were being audited, for example, infection control and health and safety. However, these had not uncovered the issues we identified during our inspection and had not recognised where people were put at risk of harm or where their health and wellbeing could be compromised. The health and safety risk assessment carried out by the registered provider in October 2016, stated that window restrictors were being maintained, but these were not in place. They also identified that carpets needed to be replaced, but had not taken prompt action to do so.

Infection control procedures were discussed in a staff meeting in February 2017, where the registered manager reminded staff to clean commodes and beds. However, we found that the infection control systems had not been effective. The registered manager told us they were frequently undertaking spot checks around the service, but had failed to recognise other obvious risks to people's health and safety. For example, paints and a bottle of sun lotion were left where they could be accessed by people with who were living with dementia, and who may not realise that consumption of such substances could be dangerous.

Other areas of auditing, such as care plans, had also failed to identify where improvement was needed, such as best interests documentation, and more detailed recording of people's life history and leisure interests. Activity provision was not sufficient, and we saw that in a staff meeting held in March 2017, the registered manager had said in respect of activity provision, "Let's see more going on." We did not observe this to be the case. There had been a lack of action to address this and ensure improvements were made.

The provider and registered manager had failed to recognise potential harm to people using the service, and their non-compliance with regulatory requirements.

All of the above constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were logged along with actions taken. A monthly audit was also undertaken to identify any recurring themes. We saw that monthly accident reports had been recently reviewed, and this

detailed people's progress, for example, referrals which had been made to the falls team and on-going monitoring.

Staff were clear on their roles and responsibilities. They told us they felt supported by the registered manager and could go and talk to them if they had concerns. One staff member told us, "The [registered manager] is very good. I get on with them. I'm very open with my opinions, but [registered manager] always listens." Another said, "I can't fault [registered manager]. Always takes time to listen to you, and they sort out any issues you have."

Staff meetings were held in the service so that information was shared and known across the staff team. Minutes form the staff meeting in March 2017 showed that relevant items were discussed such as safeguarding, body maps, planning for the summer party, room checks and infection control. The meeting was well attended by staff. The registered manager had also set up a 'Facebook' page (social networking site on a computer) where they posted updates for staff and training availability.

People and visitors we spoke with told us they thought the home was well managed and described the registered manager as approachable and fair. One person said, "I'm very content, I love it here, I've got no grumbles at all". Another said, "I have lived here for years, I'm happy living here." One relative told us, "About six weeks ago I came up and had a meeting with the [registered] manager to let them know what's happening. Otherwise I just have informal chats that have always been fitted around me. Yesterday they chatted with me for 10 minutes after the doctor had been." Another said, "I'm very happy with the care [relative] is getting. They [registered manager] have sent me a questionnaire every so often that asks about [relatives] care. Unmistakably it is a nice home and they are good girls [staff]."

The registered manager told us that questionnaires were sent out to people, relatives and professionals every six months to gain feedback. We saw some comments from 2016 made by professionals. One said, "Well managed", and "Happy residents, as well as staff." Another said, "I find the care in this home to be of good quality." We also saw that relative's feedback was positive. We did not see any written feedback from people, but the registered manger was aware this needed to be improved.

The registered manager told us they were developing links with the 'Purple Angel Alliance' which upholds the principle that people with dementia have a right to enjoy a good quality of life and continued involvement in their local community so far as they are able and willing to do so. Staff in the service had already completed a training book, and the longer term plan was to become accredited as a 'Purple Angel Ambassador'. The guide they showed us gave key information on how to promote a 'dementia friendly' environment and included numerous ideas of activity which people could enjoy. This information should guide and support improvements in the service going forward.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Activity provision was not sufficient to meet everyone's needs. The range of activities available were not always appropriate or stimulating for people living with dementia. Care plans were not consistent across the service and did not always fully reflect information on people's social needs or life history. The provider had not maximised the suitability of the premises for the benefit of people living with dementia. Equipment which could be used to maximise people's independence had not been provided. 9 (1) (3) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was did not follow the duties and responsibilities under the deprivation of liberty safeguards so that people's human rights were respected. Some people may have been illegally deprived of their liberty. 11 (1) (3)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises because the registered provider had failed to recognise or take action to improve this. Infection control procedures were not effective. Cleaning schedules were not consistently completed, and had not been monitored to identify areas of poor cleanliness and malodours in the home. Kitchen areas were not cleaned to a high standard putting people's health at risk. Regulation 15 (1) (a) (b) (c) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and/or safety were being compromised 17 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to ensure that people's needs were met at all times. Staffing levels were not being reviewed continuously to ensure they were sufficient to meet people's needs. 18 (1)