Care Quality Commission

Care UK Community Partnerships Limited

Darlington Court

Inspection report

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Ratings

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

Overall summary

The inspection took place on 24 and 25 February 2015 and was unannounced.

Darlington Court is a privately owned care home that provides nursing care for up to 61 people. At the time of our inspection, there were 46 people living at the service. This includes people who have general nursing or residential needs and people who live with dementia or have mental health needs. In addition the service provides short stay rehabilitation. This is for people following surgery or other hospital treatment before returning home, or for people who are receiving treatment in order to avoid admission to hospital. Darlington Court is a purpose-built home on the outskirts of Rustington; all bedrooms have en-suite facilities. The home is arranged in two suites, each with its own lounges, dining room and kitchenette. There is an activities room and hairdressing salon.

The service has 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.

People did not always have call bells within reach, so that they could not summon staff speedily when they needed

Summary of findings

help. Staffing levels were not sufficient to keep people safe. Where people had developed pressure ulcers, their wound care was not managed safely as staff lacked the necessary knowledge and skills. People's medicines were not always administered safely as there were gaps in the recording. Medicines were stored safely, but there was an overstock of some medicines which were old stock.

Staff knew how to recognise signs of potential abuse and what action to take to keep people safe. The provider followed safe recruitment practices. People were protected against the risk of infection. Laundry was managed in line with safe practice and clinical waste was disposed of appropriately.

The majority of people were supported by staff to have their nutritional needs met. However, some people did not receive the support they needed. There was a variety of choice on the menu and the dining areas were made welcoming for people with attractively laid tables and drinks on offer. People had access to healthcare professionals and a GP visited the service daily. Milton Unit was in the process of being refurbished to meet the needs of people living with dementia. However, some aspects were not made easily understandable or accessible for people, such as notices or signage. Staff were trained to at least Diploma Level 2 in Health and Social Care and received regular face to face supervisions with their managers. They understood the requirements of the Mental Capacity Act (MCA) 2005 and involved people in the decision making process.

People were looked after by kind, caring and compassionate staff and they were involved in planning their care. They were treated with dignity and respect and their relatives and friends could visit at any time. As they reached the end of their lives, people were cared for and supported to have a comfortable and pain-free death.

Some people felt that care was not personalised to meet their needs. Activities were organised, but many people chose not to be involved with these or were unable to participate fully because they needed one to one support. There was limited access to the community, unless people's relatives and friends took them out. There was an inconsistency in the way information was recorded in people's care plans, with a risk that people's care needs were not assessed accurately. Staff knew people well at a personal level and understood the way they preferred their care to be delivered.

Systems for measuring the quality of the service were not sufficient to drive continuous improvement nor to feed into the strategic direction of the service. Care records were at risk of being completed inconsistently and complaints had not always been handled in line with the provider's policy.

People were involved in developing the service, as were their relatives. Regular meetings were held and satisfaction surveys sent out.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not always safe.

Staffing levels were not always sufficient to meet people's needs.

Where people had pressure ulcers, these were not always managed safely. Risks were identified and managed safely.

There were gaps in the recording of the administration of medicines.

The provider followed safe recruitment practices.

People were protected against the risk of infection.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The majority of people had sufficient to eat and drink, but some people were not given the support they needed by staff.

Milton Unit, which cared for people living with dementia, did not always meet people's visual or accessibility needs.

Staff received all necessary training, understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. However, some staff were not up to date with their training.

People were supported to maintain good health and had access to healthcare services.

Is the service caring?

Good

The service was caring.

People were cared for by kind and considerate staff and were supported to be involved in the planning of their care and to express their views.

People were treated with dignity and respect.

As they reached the end of their lives, people were supported to have a pain-free, private, comfortable and dignified death.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive care that was personalised or reflected their needs.

Activities were organised, but some people were disengaged or unable to participate in these.

Summary of findings

There was an inconsistency in the way information was recorded and analysed in people's care plans.

Complaints were acknowledged and resolved within 28 days, however, the provider did not follow-up complaints with the complainant in line with their policy.

Is the service well-led?

Some aspects of the service were not well led.

There were quality assurance systems in place, but no processes that analysed the quality of the care delivered to inform future planning.

People were involved in developing the service and they had been asked for their views through questionnaires, as had their relatives.

Staff meetings were held at least four times a year and staff felt supported by management.

Requires Improvement

Darlington Court

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.

The inspection took place on 24 and 25 February 2015 and was unannounced.

Two inspectors, a nurse specialist and an expert by experience with an understanding of older people undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. 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. We also spent time looking at records including 13 care records, eight staff records, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service.

On the day of our inspection, we spoke with 13 people using the service and eight relatives. We spoke with a representative of the provider, the registered manager, one healthcare assistant (team leader), two registered nurses, three care assistants, including two agency workers and one member of domestic staff.

The service was last inspected in August 2014 and found to be non-compliant in a number of areas.

Requires Improvement

Is the service safe?

Our findings

At lunchtime in Milton Unit where people who lived with dementia were cared for, one person who could not reach his call bell, was trying to get out of bed. His legs were hanging over the side of the bed and he was trying to get up. Staff in the unit were busy in the dining area and we asked for someone to assist the person, as he was at risk of falling. One member of staff said, "Oh that's [named the person]. He looks like that. He's got Parkinson's". Our observation was of someone trying to get out of bed and who needed help. A relative told us, "I think they could do with more staff at lunchtimes. I come in to help out because they can be a bit short". Several people were unable to reach their call bells as they were out of reach in their bedrooms.

Staffing levels were assessed, but did not always appear to be sufficient to meet people's needs. One person thought that staffing levels were not always adequate, especially at night when one registered nurse and three care staff were on duty on the first floor to look after 35 people when the unit was at full occupancy. They said that on one occasion, a care assistant had failed to attend, so that two care assistants had to cover the work. This person told us, "I feel safe, but sometimes I do not feel safe, especially when staffing levels are low. What if there is an emergency?". People said that call bells were usually answered promptly, but sometimes, "It can be several minutes when they're busy". Another person told us, "I don't always think they have enough staff. Why can't they come to me? I'm always last and I have to wait". The registered manager felt that staffing levels were sufficient and assessed in line with people on the first floor who had a range of needs. She said that people could be admitted to the rehabilitation service at short notice and that assessments of people's needs were undertaken promptly.

These matters were a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had developed pressure ulcers, nursing staff were not providing safe wound management. Two people had acquired grade three pressure ulcers in hospital prior to their admission to the service. We were unable to check one person's pressure ulcer as they were admitted to hospital on the day of our inspection, for treatment of other medical conditions. The other person's pressure ulcer was not managed properly. There was no current wound care plan to show how the pressure ulcer was managed. An unrealistic objective had been set that the person should receive hourly turns, which would have been difficult to maintain whilst promoting the person's comfort, especially during the night. There was a lack of knowledge and skills from nursing staff in choosing the appropriate dressing. The use of inappropriate dressings had damaged the surrounding skin of the pressure ulcer. Particular types of dressing had been selected in a random way by nursing staff, without thought as to whether they were the correct dressing to treat the pressure ulcer. We asked the unit manager and clinical manager why no referral had been made to a tissue viability nurse (TVN) and were told that the TVN did not always follow-up their referrals. On the second day of our inspection, the registered manager said that the person's GP had been contacted and they had made a referral to the TVN.

Action was taken to prevent people from the risk of developing pressure ulcers. People who were identified as being at risk were provided with alternating pressure relieving air mattresses with functioning profiling beds. Turning charts recorded that people were turned every two to four hours and these were checked daily by the registered nurse to ensure the charts had been completed fully and the appropriate care had been delivered. There was a mattress check list which showed how the effectiveness of the mattresses was monitored. Mattresses that we checked were set correctly according to the person's weight. Staff demonstrated a good understanding about the settings of mattresses and put this into practice. Care staff demonstrated a good understanding in the prevention of pressure ulcers, but needed more training on wound management.

People's medicines were not always managed so that they received them safely. There were some shortfalls because of unexplained gaps and recording in the Medication Administration Records (MAR) sheets. For example on 21 February 2015, an entry of Simvastatin 40mg for one person was not signed by staff. On 22 February 2015, an entry of Citalopram 20mg for another person was not signed by staff. This meant that people may not have been given their prescribed medicines when required. There was an excessive stock level of some medicines. For example, there were 448 tablets of Paracetamol 500mg for one person dating back from October 2013 and January 2014. Another person had 200 tablets of Paracetamol 500mg from

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Is the service safe?

December 2012 and January 2013. There were also excessive stocks of Lansoprazole and Trimethoprim. Old medicine stock balances were not being carried forward to add to the new stock. During our visit, the registered manager said that the unneeded medicines had been disposed of.

These matters were a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored in a small clinical room near the nurses' station on the first floor. There was a medicines trolley securely locked in front of the clinical room and a fridge dedicated to the storage of medicines that were required to be stored at a low temperature. The fridge was monitored daily and temperature readings taken and recorded on a fridge temperature chart, which showed it was working effectively. Controlled drugs were securely stored in a metal cupboard in the clinical room in line with legal requirements. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and misuse of drugs regulations. Controlled drugs were audited daily by the nursing staff. We observed medicines being administered to people during the afternoon. People were given their medicines carefully so that they received the correct type and dosage. The registered nurse waited patiently for each person to swallow their medicine. No-one was administered medicines covertly and no-one managed their medicines independently.

People said they felt safe and were protected from avoidable harm. They told us they would speak with staff if they were worried or unhappy about anything. One person said, "I do feel safe and content here, yes". A relative told us, "Where she was previously I was never 100% about her being really safe, but here I am. I know they're always popping in to check on her".

Staff recognised the signs of potential abuse and knew what action to take. Staff demonstrated a good understanding, knowledge and awareness about safeguarding adults at risk of abuse; they knew how to report any cases. One member of staff said, "It is our responsibility to protect people under our care from abuse. I will report any case of abuse".

There had been a number of safeguarding concerns at the service. The local safeguarding authority were due to visit to support staff to have a better understanding of protecting adults at risk. The registered manager told us, "Staff now understand what the impact of their actions was". Staff meetings had been organised so that staff could discuss why and how safeguarding alerts had been brought about and lessons were learned.

The provider was working closely with the local authority where failings had been identified previously in the management of risk. Training needs had been identified for staff in areas such as moving and handling, catheter care and infection control. Risk assessments for falls, pressure ulcers, nutrition, moving and handling and the use of bed rails were contained in care records, with relevant action plans in place to manage the identified risks. Some people who were at risk of choking due to swallowing problems had been assessed and appropriate action taken. Risk assessments and care plans were up to date and had been signed by the person or their relative to show they had been involved.

Accidents and incidents were documented and we saw records relating to the reporting of these for October, November and December 2014 and January 2015. Details of the accident or incident were logged which showed the date and time it had occurred, the person's name and the nature of the injury. There was no evidence to show that accidents and incidents were reviewed or that they were used to inform the planning of care.

The provider followed safe recruitment practices and statutory checks were undertaken to ensure that new staff were safe to work with adults at risk. A relative referred to staff and said, "They are excellent and competent. It's much improved. There were a lot of new staff before who hadn't been trained to hoist and that sort of thing, so although the numbers of staff were around, what they could do was limited, but that's all sorted now". Gaps in staffing rotas were filled by agency staff and the provider endeavoured to use the same agency staff who knew people well.

People were protected by the prevention and control of infection. The environment looked clean with no lingering, unpleasant smells evident. Staff demonstrated a good understanding and awareness of infection control and knew how to minimise the spread of infection in the care and treatment of soiled linen and clothes. Trolleys were used to transfer items that needed washing to the laundry. There was a labelling machine in the laundry for affixing names to people's clothes. This ensured easy identification

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Is the service safe?

and helped to reduce the incidence of misplacing people's clothes. Staff wore protective aprons and gloves when delivering personal care and washed their hands using alcohol gel and disposable paper towels. Clinical waste was disposed of appropriately.

Requires Improvement

Is the service effective?

Our findings

The majority of people were supported to have sufficient to eat and drink and to maintain a balanced diet. People could choose where they wanted to eat their meals and there were two main choices available on the menu, together with a range of alternative choices such as omelette or jacket potato. People's comments on the food ranged from, "It's ok" to "The food's very good and the new chef has started introducing some more variation". People chose what they wanted to eat the day before, but could change their minds when the meal was served. Generally, the main meal was served in the evening, with lunch consisting of a hot food choice, soup or sandwiches. Special diets were catered for. At lunchtime the dining areas were welcoming and tables were attractively laid with tablecloths, serviettes, cutlery and glasses of juice. Most people preferred to eat in the dining areas and people who needed one to one support with their meal were provided with this. However, we observed one person being assisted by a member of care staff to eat their meal and this looked to be an unpleasant experience. The care assistant was hurriedly putting spoonfuls into the person's mouth without waiting for him to finish each mouthful. The person was moving his head from side to side so that the food ended up over his face and was also falling off the spoon as the care assistant served it. The food was pureed all together on the plate, rather than separated out into food groups.

One relative was a little concerned about his wife's eating and drinking. He thought she had lost weight and he did not know how staff monitored her food and fluid intake. He said, as far as he knew, there had not been a review to discuss her care plan and talk this through. He mentioned that when he arrived after lunch, his wife's meal was, "Only poked at and hardly touched. Sometimes she can't reach her drink either and she can get bladder infections if she doesn't have enough fluids". Another relative said that fluids were not always within people's reach and we saw that jugs of water were not always within reach of people in their rooms. This meant that people were at risk of dehydration and of contracting urinary tract infections due to insufficient fluid intake. However, care records showed that people who had lost significant weight in the last three months had been seen by a GP. There was evidence of food and fluid charts being completed and people were weighed monthly and their weights recorded. The registered nurse demonstrated good knowledge and skills of managing weight loss. She said, "Normally when a resident loses weight we will inform the GP and refer to a dietician, then follow the instruction given on how to manage the resident". The service had identified risks to people and taken appropriate action.

People were supported to maintain good health and had access to healthcare services. People felt that medical attention would be sought when needed and relatives were very impressed with the medical care and attention their family members received. Relatives told us, "They'll call the doctor as often as they need to, so if they're not happy, they'll call them again". Another relative said, "She had two falls and they called the doctor straight away to check her over". People also spoke of having their hair done, chiropody, manicures and eye tests. A GP visited the service daily and multi-disciplinary meetings took place. These meetings were attended by health and social care professionals and reviewed people's care and progress. The nursing staff flagged up anyone who needed to see a GP. Physiotherapists and occupational therapists worked on site to support people's rehabilitation and progress, if possible, back into the community. When people left the service, everything was put in place to ensure a smooth transition if they returned home. Care records confirmed the involvement of healthcare professionals.

The unit on the ground floor that cared for people who lived with dementia (Milton Unit) was in the process of being redecorated. The process had been started and contrasting colours had been used on walls in order to aid people's orientation around the service. Pictures of Hollywood stars were used to decorate the corridors. The registered manager told us that corridors would be painted in different colours with some visual areas such as a beach theme or seasons of the year. In the Milton Unit a noticeboard displayed a hairdressing price list and details of a fundraising event for Red Nose Day. There was an invite from a local retailer who was bringing in ladies' clothes for people to buy. None of the notices were planned in a way to make them accessible for people who lived with dementia. There were some signs on doors that depicted what the room was used for, but pictures and photos had not been utilised as much as they could have been, to aid people's comprehension and understanding. The lounge area in Milton Unit had been adapted to meet people's needs with the use of bright contrasting colours and pictures.

Requires Improvement

Is the service effective?

People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff received essential training on fire evacuation, moving and handling, infection control, mental capacity, safeguarding adults at risk and dementia awareness. Learning was delivered on line or face to face through the provider or local training organisation. Nursing staff received clinical training in venepuncture, wound care, catheterisation and syringe drivers, although some staff did not know how to manage pressure ulcers safely. However, audits showed that staff training had not always been refreshed in a timely fashion.

New staff would start to study for a Diploma at Level 2 in Health and Social Care by the end of their induction training and they were encouraged to progress to Level 3. Induction was completed within 12 weeks and comprised work shadowing and e-learning. The registered manager said, “They’re all up for training” and that all staff were invited to participate in training, even on topics that might not relate directly to the care they delivered. Six staff had attended bereavement training delivered by a local funeral director and other staff had attended end of life training delivered by a local hospice. Staff felt they had the right skills and knowledge about people’s preferences, choices, likes and dislikes, in order to deliver personalised care. One person said, “Oh yes, they know what they’re doing, they’re very good indeed”.

Team leaders could be champions in certain areas, for example, in dementia awareness, care planning and end of life training. This meant they had a greater awareness in these areas and could support care staff effectively. The registered manager told us, “It’s important to offer opportunities to staff”. Team leaders were also being trained to supervise staff and the registered manager had organised mock supervisions to equip them with the skills they needed.

Staff said they received supervisions and face to face meetings with senior staff every four months. However, only supervision records dating back to January 2015 were available. Staff meetings were held at least every two months, sometimes on a monthly basis. Performance issues were also discussed at staff meetings. There were no records to show that appraisals had taken place.

Staff understood the relevant requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. Staff received training in this area as part of their induction programme, then it was refreshed annually. Physical restraint was not used. Some people living with dementia could become upset and staff knew people well. They knew how to intercede and had learned techniques to manage inappropriate behaviours or conversations. Care records showed that capacity assessments had been undertaken which identified whether people had the capacity to make decisions. Where people were unable to make big decisions, then best interest meetings were held, which is where people, relatives and professionals make a decision on someone’s behalf. The registered manager told us that it was, “Important to include the person as it’s about them”.

People who were cared for in Milton Unit were deprived of their liberty, as access was only possible via a keypad. The registered manager had completed applications for everyone living on the ground floor in line with the legal requirements of Deprivation of Liberty Safeguards (DoLS) and was awaiting authorisation from the local authority. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People gave very complimentary feedback about the caring nature of staff and the service. Comments were, "I'm very pleased here. They're always cheerful, happy and obliging", "It's wonderful, I'm quite content here. The girls are so nice and I certainly do get well looked after" and "They're very friendly, know what they're doing and I really have no complaints at all".

At one point in the day, a member of staff came in with a drink for one person and was very polite and smiling. The person said, "She's lovely she is, but then they all are". Staff were kind, gentle and had a warm approach with people. There were many interactions that were caring and respectful, such as, "Oh your coffee's gone cold, can I make you a fresh one?" and "Would you like the window closing, I don't want you to get cold there". Relatives too were positive. One said, "If you're upset, they'll give you a hug and a cup of tea" and another said, "If you were bringing your mother here, I'd tell you, 'It's friendly, homely, clean and she'll be well cared for'".

People were supported to express their views and were involved in making decisions about their care, treatment and support. People were asked about their day to day care as care tasks were being undertaken. A relative said, "[Named family member] can't be in a wheelchair for any length of time as she has a pressure point, so they make a decision with her on a daily basis about how much time she should spend out of bed". Another relative said, "The process is that they review and update the care plans themselves and then we get it to look at and make comments, which I write on the back and give it back to them".

One person said that staff always told her when they were writing and updating the care plan. Another person described how her care plan had just been updated because her condition had improved, which had changed some of her care needs. She said that the nurse had discussed these changes with her and she had signed the care plans. Evidence from care plans showed that people's choices and preferences were clearly stated.

Accessible communication was used, in line with people's individual needs, to enable them to express their views. For example, we saw one lady being encouraged to communicate supported by her relative, using a laminated board with letters of the alphabet, so that the lady pointed to each letter.

People were treated with dignity and respect. One person thought that care staff treated her kindly at all times. Care staff were not just task orientated, but were interactive, polite and communicated with people in a sensitive and empathic way. Relatives and friends were able to visit without undue restriction. One relative told us, "I once couldn't make it until 10 pm and it was absolutely not a problem. I feel confident that if I came at 7 am in the morning there wouldn't be a problem. It's a very open place".

People were supported at the end of their lives to have a private, comfortable, dignified and pain-free death. A relative was visiting the service for the first time since their family member had passed away. They said, "They're like family, 100% care, we couldn't speak more highly of them. The end of life care for mum was unbelievable. It was so genuine and came from the heart. For mum this wasn't just a home, it was her home. Truly amazing, she was never in any pain. The staff were sitting with her when she died". Some people were on an end of life management plans and they had 'Do not attempt cardiopulmonary resuscitation' forms in place. These had been signed by the GP and showed that the decisions had been discussed with the person's family, where family was present. All people on end of life care had their care plans updated monthly.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. One person told us, "I would love to have baths more often". Their relative told us, "It really helps relax her muscles and then she sleeps better. She gets washed twice a day, but we only managed to get a bath on the care plan for once a week, but that doesn't happen and I have to remind them. She's also supposed to have her teeth brushed twice a day as she has swallowing difficulties, so food gets stuck, but it only happens once, so her dental hygiene is an issue". Another person said, "If I was at home, I'd like to have two showers a week and I can have one here, but you have to ask for one if you want one".

One person was calling from a chair in her room for some time. She was seated behind an open door which was blank. She had visual problems and was troubled by a light in the corridor which was only just in view, as the blank door was blocking anything else. She could not reach her call bell and told us she needed the toilet. We handed her the call bell and someone did come promptly and was very kind to her. However, the whole sequence of events took nearly half an hour and would have been speedier if the call bell had been within the person's reach. Call bells were not easily accessible for some people when they were out of bed and sat in a chair; the wires did not appear very long.

During the morning, seven people were in the lounge at Milton Unit with the activities co-ordinator. People were sitting around the table looking at old pictures and there were some discussions taking place of a reminiscence nature. However, whilst four people were engaged in this activity, others were not. On the second day of our inspection, people were gathered in the same lounge and a variety of coloured balls had been placed on a table in the middle of the room. People were unable to engage in the activity on offer without one to one support. Relatives were visiting and were engaged in separate activities with their family members.

Relatives told us that activities were provided regularly for people to be involved in if they wished. There were photographs on the walls of recent Valentine's Day celebrations. One relative said, "It would be good, as [named relative] is younger than the others in here if someone could at least come and spend a bit of time with her, having a chat and that sort of thing, not just when they're doing her care. The sorts of activities they have tend to be for much older people, which doesn't interest her". Another relative referred to their family member and said, "She doesn't tend to go into the activities as she's never really been a group type of person. Music was always our life". When asked if this featured in their family member's life at the service, they said, "No, not at all". Our overall impression was that, whilst activities were on offer, people were not involved in the planning of these and that people's individual preferences with regard to occupational and social input was poorly attended to on a regular basis.

People told us they went out into the garden when the weather allowed. On the day of our visit, all the doors to the garden were locked. Other than the garden, it appeared that people usually only accessed the community if they were taken out by their relatives or friends. People appeared to keep to their rooms unless staff supported them to move around the service, for example, to access the dining area at lunchtime.

There was a risk that people's care could be recorded electronically in a way that did not accurately reflect their needs. For example, one person's weight had been recorded and showed that there had been fluctuations in weight since September 2014. Using the Malnutrition Universal Screening Tool (MUST) which identifies adults who are malnourished or at risk of malnutrition, she had been assessed as 'high risk', yet staff had ticked a box electronically answering 'no' to the statement, 'Is person eating poorly or lack of appetite?'. Food and fluids had been recorded on the computer system which demonstrated this person had an appetite that was extremely variable over the days we checked. Nevertheless, this person was then assessed, using the Waterlow screening tool, as being at low risk, despite evidence that clearly contradicted this on the system. (Waterlow is a tool designed to assess people's risk of developing a pressure ulcer and takes account of a number of factors, including nourishment.)

These matters were a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments and care plans were reviewed monthly, although these could be reviewed earlier if there were any changes needed. Care staff told us that the registered nurses were involved in updating care plans and that they relied on handover meetings to find out about people's

Requires Improvement

Is the service responsive?

latest care needs, rather than referring to records. When people were admitted into the rehabilitation unit, care plans were usually done within 24 hours and, at the latest, within 72 hours. The registered manager said that people underwent a pre-assessment before being admitted to the unit. This meant that care staff could address people's care needs promptly and have a rehabilitation programme drawn up quickly. Written care records were comprehensive and detailed. Each person had a written care and nursing care plan and care plans were also kept electronically. Care staff entered how they cared for people within an online daily record.

There had been eight complaints made to the service within the last 11 months and these had all been acknowledged within seven days of receipt and resolved within 28 days. However, there was no evidence from files that the complaint had been resolved to the satisfaction of the complainant. The provider's policy stated, 'When investigations are concluded, we will arrange to meet you to discuss the outcome'. There was no evidence to suggest that such meetings had taken place. A comment box on each complaints stated, 'Complainant's comments on outcome' – these were all blank.

However, staff did know people well and paid attention to detail. One relative told us, "Mum couldn't speak, but used to make sing noises, you know like the different cries and sounds a baby makes. Well they knew the noises she made and what it meant". Another relative said, "We had a blanket made for mum with family pictures on and a carer noticed it was upside down for mum to look at. We hadn't even noticed, but she did. Little things like that mean a lot to people in here". Another comment by a relative was, "If she's coming out of her room, they'll always make sure her hair is nice and she has make up on if she wants to. They always ask her what she wants to wear".

The majority of people were given a choice about who delivered their personal care and were asked whether they minded what gender their carers were. Some people said they had not been asked, but that it was not an issue.

People said they were happy and comfortable in their rooms. There were memory boxes outside people's rooms in Milton Unit which contained items that were important to people, such as small knick-knacks and photos. Some rooms were more stimulating than others, for example, in one room there was a large 'Trip down Memory Lane' poster at the end of the person's bed which was bright, visual and personal to the person. Other rooms only had blank walls and were not personalised.

Requires Improvement

Is the service well-led?

Our findings

There were quality assurance and governance systems in place, however, these were not sufficiently robust to drive continuous improvement. When incidents or accidents occurred, these were not analysed to identify any patterns or to inform future strategy. A provider's recent visit had identified, 'Poor review of accidents and incidents'. It was unclear whether management had a full understanding of why incidents or accidents were audited or reviewed to minimise future risk. The registered manager had completed audits in a range of areas and identified actions to be taken. For example, in January 2015, only 40% of staff were compliant with staff fire evacuation training, 70% compliant with moving and handling training, 45% compliant with Control of Substances Hazardous to Health (COSHH) and 70% compliant with health and safety awareness training. A deadline date by which staff needed to complete this training was given as 1 February 2015. However, there did not appear to be any system that had been formulated to ensure that action was taken and prevent the risk of staff not being up to date with their training in the future.

Care records, which were kept in a written and electronic format, were at risk of being completed inconsistently so that people's most up to date care needs were not accurately reflected. The complaints procedure did not identify whether complainants were consulted on the outcome.

These matters were a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in developing the service. Residents and relatives' meetings were held bi-monthly and these were advertised through notices and in the provider's newsletter which was sent out every two months. When new staff were recruited to the service, they were shown around by the registered manager. She told us, "We take candidates round and it's really important to see how they interact with residents".

Staff meetings were held at least four times a year. Staff told us they felt supported by management and that the current team was, "Very caring and committed". One member of staff said, "The manager and clinical manager are very good and supportive" and another staff member said, "The manager is very supportive and approachable".

People felt this was a well run service with a culture of speaking up about any issues or concerns and that all the staff were approachable. One person said, "You always know you can speak to anyone and the manager's door is always open for you". A relative said, "I've learnt it's much better to get anything off my chest before I go home and then worry about it". Everyone we spoke with thought that communication was good.

A satisfaction survey had been sent out to relatives in 2014 and to residents in February 2015. The overall feedback was positive, with statements like, 'I am happy with the care and support I receive', 'Staff have time to talk to me' and 'Staff are sensitive to how I'm feeling'. When asked about the quality of the catering, one relative said, 'Sometimes meals don't look very appetising, quality varies, some are excellent'. Another relative had stated, 'One big happy family. Would not hesitate in recommending the home to other people'.

The registered manager had only been in post for a few months. When asked to describe the culture of the home, the registered manager told us, "I think it's task orientated and that's what I'm trying to change. It's ok to sit down with people, have a cup of tea and a chat". She said her vision was, "To sort out the dementia unit. I want this home to be one of the flagship homes for Care UK". People and staff felt that communication was good and there was an open door policy. The registered manager's office was next to the entrance so she could see who came and went. She said, "Staff can always pop in for a chat. I like to think staff find me approachable". The registered manager felt supported by senior management. She told us that monthly meetings were arranged with other registered managers from Care UK which was a supportive network. When asked what she thought was a challenge in managing the service, the registered manager said, "Using agency staff" and that this was a high cost to the service. However, there were plans to recruit one new member of care or nursing staff every six weeks, to manage the overlap between staff leaving and joining.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not take appropriate steps to ensure that, there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not ensure that care and treatment was provided in a safe way for service users or assess the risks to the health and safety of service users of receiving the care or treatment, nor do all that was reasonably practicable to mitigate any such risks. The provider did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not ensure that systems or processes were established and operated effectively to ensure compliance nor did they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (1) (2) (b)