London Residential Healthcare Limited

Tilford Park Nursing Home

Inspection report

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Date of inspection visit:
01 August 2016

Date of publication:
30 August 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Tilford Park Nursing Home provides nursing care and accommodation for a maximum of 42 older people who may be living with dementia. At the time of this inspection there were 38 people living at the home, all apart from two who were living with dementia.

This was an unannounced inspection which took place on 01 August 2016.

During our inspection the registered manager was present. 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 told us that they felt safe in the home. However, staffing levels did not ensure that people who lived with dementia received all the support they required at the times they needed. We observed that staff were rushed and had little time to spend with people outside of delivering care to them. You can see what action we told the provider to take at the back of the full version of the report.

Staff had some understanding of the Mental Capacity Act 2005 (MCA) and of the Deprivation of Liberty Safeguards (DoLS) and had received training in these areas. People's representatives had not always been involved in decision making processes when people lacked capacity to consent to ensure their rights were upheld. You can see what action we told the provider to take at the back of the full version of the report.

People said they were happy and comfortable with their rooms and we saw that they were attractively decorated with some personal touches including photographs and memorabilia. However, some elements of the environment didn't lend themselves to assisting the needs of people with dementia. We have made a recommendation about this in the main body of our report.

Staff said that they received sufficient support and training to fulfil their roles and responsibilities. Training was provided during induction and then on an on-going basis. A training programme was in place that included courses that were relevant to the needs of people who lived at Tilford Park Nursing Home. However, at times some staff did not demonstrate sufficient understanding when supporting people who lived with dementia. We have made a recommendation about this in the main body of our report.

Everyone that we spoke with said that the manager was a good role model. Quality monitoring systems were in place that included seeking the views of people in order to drive improvements at the home. Checks were not always completed in line with the provider's policy and action plans were not always recorded to improve identified shortfalls. We have made a recommendation about this in the main body of our report.

Potential risks to people were assessed and information was available for staff which helped keep people safe. However, at times staff restricted people's movements without a clear rationale being in place. We

have made a recommendation about this in the main body of our report.

People said that in the main they were happy with the choice of activities on offer and that they were supported to maintain links with people who were important to them. Access to further stimulation would enhance people's wellbeing further. We have made a recommendation about this in the main body of our report.

People were treated with kindness and compassion. Although we observed that staff at times appeared busy and rushed we saw no signs of impatience with people. Staff appeared dedicated and committed. We observed that care was given with respect and kindness but it was clear that some people had to wait for too long for the help they required.

Robust recruitment checks were completed to ensure permanent staff were safe to support people.

People said that they were happy with the medical care and attention they received and we found that people's health needs and medicines were managed effectively. People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan.

People said that the food at the home was good and that their dietary needs were met. There were a variety of choices available to people at all mealtimes.

Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff were able to describe safe moving and handling techniques.

Information of what to do in the event of needing to make a complaint was displayed in the home. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place.

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.

At times there were not enough staff on duty or deployed to support people and to meet their needs at the times they wanted.

Risks were assessed and managed but at times staff restricted peoples' freedom of movement without justification.

Staff employed by the registered provider underwent complete recruitment checks to make sure that they were suitable before they started work.

People told us they felt safe. Staff understood the importance of protecting people from harm and abuse.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People consented to the care they received. However, at times the requirements of the Mental Capacity Act 2005 were not followed in full.

Some effort had been made to ensure the design and decoration of the home was suitable for people who lived with dementia. Further work should take place to enhance people's quality of life.

Staff were received training and support to care for people. Further dementia care training should be provided to increase staffs understanding and practice.

People were supported to eat a choice of meals that promoted good health.

People told us that they were happy with the medical care and attention they received. People's health and care needs were managed effectively.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by dedicated and committed staff.

People were supported to express their views and to be involved in making decisions about their care and support as much as they were able.

People were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and treatment was provided in response to their individual needs and preferences.

People's health care needs were responded to appropriately.

An activity programme was in place and in the main people expressed satisfaction with the range of activities available.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality monitoring systems and were being used to identify and take action to reduce risks to people and to monitor the quality of service they received. However, checks and records were not completed in line with the provider's policy.

The registered manager promoted a positive culture which was open and inclusive.

People spoke highly of the registered manager and said that the home was well-led. Staff felt well supported and were clear about their roles and responsibilities.

Tilford Park Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 01 August 2016 and was unannounced. The inspection team consisted of two inspectors 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 the inspection, we asked the provider to complete 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 reviewed the completed PIR and we checked information that we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the home. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with 11 people who lived at Tilford Park Nursing Home and five relatives. We also spoke with two nurses, a team leader, two care staff and the registered manager.

All apart from two people at the home were living with dementia and we were unable to hold detailed conversations with many of them. In order to understand their experiences of living at the home we spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for seven people and other records relating to the management of the home. These included staff training, support and employment records, quality assurance reports, policies and procedures, menus and accident and incident reports.

Tilford Park Nursing Home was last inspected on 30 May 2014 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People's views on staffing varied. A relative said, "Levels are pretty good. Sometimes weekends they are short. I don't know why but it's always at a weekend." One staff member told us, "There's always plenty of staff. I do have time to spend with people." Another staff member said, "We work as a team. If staff are finished (providing care for people) upstairs, they will come down and help out." A third staff member told us, "Some days are busier than others but things get done."

At times, staff were not deployed in the home to the needs of people who lived with dementia were met safely. We observed interactions in two communal areas over an extended period of time. During this time, between six and eight people were present. There was no permanent staff presence in the smaller lounge for the period observed and no staff presence at all for periods of up to 30 minutes at a time. In both lounges when staff were present, we noted, on several occasions, that they attempted to restrict people's movements on the grounds of safety. At lunchtime there appeared to be sufficient staff present to support people however there was no direction as to what their roles were. As a result the lunchtime felt chaotic. Lunch was scheduled at midday and some people were sitting at the dining tables at this time but it was over 30 minutes later before everyone was seated and lunch was served.

Individual dependency assessments were completed to decide staffing levels. For June 2016 these stated that there were 24 high dependency, seven medium and three low dependency people at the home. The registered manager told us that staffing levels consisted of two nurses during the day, one team leader and seven care staff in the morning and six care staff in the afternoon. At night we were informed that staff consisted of one nurse and four care staff. In addition to this an activity person was on duty five days a week with separate cleaning, laundry and kitchen staff working seven days a week.

Discussions with the registered manager, staff, examination of records and observations confirmed that staff levels had not always been maintained to the levels described by the registered manager. This impacted on the quality of service that people received. For example, on 19 June 2016 records confirmed there were four care staff on the afternoon instead of six. On the day of our inspection there was no activity person and when we first arrived at the home there was only one nurse on duty. The registered manager told us that the medicines round began at 8.30am. We observed this was still going on two hours later. We were told the next medicines round would begin at 12.30pm which meant that there might not have been a safe time between medicines rounds. There were 12 shifts during July 2016 where one nurse was on shift and not two as the registered manager described. People and relatives told us that reduced staffing levels normally occurred at weekends. The registered manager confirmed that at weekends two nurses were not always allocated to shifts. She said that this was because there were less nurse duties such as dealing with the GP. The registered manager had not assessed the impact of this along with the reduction of other staff of a weekend such as administration, management and activity persons.

The registered person had not ensured sufficient numbers of suitably qualified staff were on duty and deployed at all times to meet people's needs safely and consistently. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust recruitment checks were completed to ensure staff were safe to support people. Staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. They also included checks on eligibility to work in the United Kingdom (UK) and confirmation that nurses were registered to practice with the National Midwifery Council.

Staff did not always understand risk management and keeping people safe whilst not restricting their freedom. One staff member told us, "If someone wants to go out, say to the garden, I would go with them." We asked what the staff member would do if the person, who had mental capacity, did not wish to be accompanied. The staff member told us, "I would let them but I would watch them." Another staff member was asked what they would do if approached by a person with full mental capacity who wished to undertake an activity with an element of risk. We were told they would try to persuade or prevent them from doing so.

We observed staff guiding people who lived with dementia away from, or preventing access to, areas of the home without any apparent reason. There was an enclosed garden courtyard at the centre of the home that was accessible by doors in the lounges. When people attempted to go into the courtyard staff stopped them and people were encouraged to sit down or accompany staff to other areas. This was also the same when people attempted to leave the main lounge and walk along the corridors of the home. We did not observe any particular risk to people on these occasions or note any rationale for such close supervision. We were told the risks of people going outside were too great to allow unrestricted access. This had not been included in peoples' individual risk assessments. The registered manager said staff practice would be reviewed and action taken to allow people to access the garden and other areas of the home when they wanted to.

It is recommended that the registered person reviews practices in the home to ensure people are not unduly restricted.

Other risks were managed in a balanced and safe way. These included assessments in relation to pressure areas, malnutrition and moving and handling. Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely. One relative told us, "X (family member) has a pressure mattress on their bed. She's never had a pressure sore since she has lived here despite her skin being so fine. The staff move her regularly."

Staff were able to describe safe moving and handling techniques. Staff supported people to move safely from wheelchairs to armchairs using a hoist. They explained the process to people, telling them what was happening and provided reassurance. There was an up to date business continuity plan in place that assessed and planned for events that included gas failure, floods and power outage. Personal Emergency Evacuation Plans (PEEPS) were in place for individuals that could be used to move people safely in the event of a fire and staff were aware of the contents.

People said that they felt safe and we observed that they appeared happy and at ease in the presence of staff. One person said, "This is my place of safety." A relative said, "The staff are protective but not oppressive. I feel they are now safe, they are not frightened anymore."

Systems and processes were in place to safeguard people from harm. Staff had undertaken adult safeguarding training and were able to explain the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I've done safeguarding training. We do it every year so I feel confident I would know what to do if I suspected abuse was going on."

Another staff member said, "If I had to, I would go outside the home to make sure residents are protected."

The registered manager demonstrated knowledge and understanding of safeguarding people and her responsibilities to report concerns to the relevant agencies. For example, one person shared information with us and agreed that we could tell the registered manager. Immediately the registered manager raised a safeguarding alert with the local authority. She also put measures in place to offer assurance and to protect the person whilst the information was explored.

Apart from the timing of the medicine round on the day of our inspection medicines were managed safely. The administration of medicines followed guidance from the Royal Pharmaceutical Society. The medicines trolley was locked when unsupervised. Staff did not sign Medicine Administration Record (MAR) charts until medicines had been taken by the person. There were no gaps in the MAR charts. We noted MAR charts contained relevant information about the administration of certain drugs, for example, anti-coagulants. Staff were knowledgeable about this and all the medicines they were giving. Information concerning people's allergies, if they had them, was clearly shown on the MAR charts. In addition, each person taking 'as needed' medicines, such as pain killers, had a 'PRN' (as and when required) protocol held with their MAR chart. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects.

Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Medicines requiring refrigeration were stored in a locked fridge which was not used for any other purpose. The temperature and the room in which it was housed were monitored twice daily to ensure correct storage.

One person at the home self-medicated, that is, managed their medicines independently. They possessed full mental capacity and, as the only medicine they possessed was an inhaler for preventative use, there was a clear rationale for the arrangement.

Regular and detailed medicines management audits had been undertaken by the provider, including daily inventories of medicines given on a 'PRN' basis. We noted issues identified as a result of these were acted upon. Staff we spoke with told us there was regular training provided in medicines management that included checking their competency to administer medicines. We were shown evidence that this was undertaken as part of the supervision process.

Requires Improvement

Is the service effective?

Our findings

People said that they consented to the care they received. Systems and processes were in place that supported people's rights to consent to care. However, these had not always ensured people's rights were upheld.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

In most cases people's level of mental capacity had been assessed. However, one person had not. An application for DoLS authorisation had been made. However, there was no record of a formal MCA assessment having been undertaken. The person's pre-admission assessment and care plan indicated they were able at times to communicate and make decisions. However, the reason given for the DoLS referral was that the person 'was unaware of the risks around them.' As there was no evidence to support this and no MCA assessment undertaken, a referral for DoLS authorisation was not appropriate.

Two people received medicines covertly, that is without their knowledge or permission. MCA assessments had been undertaken to establish that each person did not understand the risks of not taking their medicines. Their records indicated their GP and family had been consulted. However, there had not been best interests meetings convened, the minutes of which would provide evidence of the reason decisions had been made. A DoLS application had been made for one person but not the other. This was not consistent with the law.

Another person had an MCA assessment completed and a DoLS referral as the assessment stated they did not have the mental capacity to agree to restrictions. However the contents of the assessment contained conflicting information and did not demonstrate that they did not have mental capacity. We spent time with this person and they were able to tell us in detail about members of their family, their employment and when they had moved to the home. Conversations with the person indicated that they were able to retain information which contradicted the MCA assessment.

The registered person had not ensured that people's rights to consent were upheld, that the MCA 2005 was followed and peoples' legal rights protected. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted in other care plans that written consent for care and treatment had been obtained from relatives and representatives where it had been established that people did not possess mental capacity.

Staff had received training on the MCA and DoLS and most had understanding of their responsibilities in these areas. One staff member told us, "DoLS is only used when someone doesn't have the capacity to make a decision for themselves." Another staff member said, "People with mental capacity can make decisions for themselves."

Although some effort had been made to ensure the design and decoration of the home was suitable for people who lived with dementia further work was needed. Hand rails in corridors were painted a different colour from the walls in order to help people see them.

The environment was very busy and noisy. We observed staff members call to each other loudly from distance on numerous occasions. A nearby kitchen door was constantly opening and slamming shut. On two occasions, a nearby laundry room door was left open whilst a washing machine was on. This was significant as it gave the impression of a place of work rather than people's homes. A calm and relaxed environment can be therapeutic for people with dementia; conversely, unnecessary noise and raised voices can cause distress in some cases.

There were very few objects of interest around the home to offer further simulation for people who lived with dementia. The provision of these would allow people who lived with dementia to have stimulation without the need of staff support. The corridors around the home had a selection of pictures on the walls. Some were old black and white pictures of local scenes. Others were rather abstract water colours with little or no detail that would stimulate conversation or interest.

The chairs in the main lounge were placed all around the edge of the room. Chairs in the smaller lounge were arranged in small clusters that encouraged conversations between people. However, staff needed to initiate conversations and as there were no staff allocated to this lounge this did not happen. After our inspection we were supplied with documentary evidence that confirmed the seating arrangements in the main lounge had been altered.

It is recommended that the registered person researches and implement's changes to ensure a dementia friendly environment.

New staff completed an induction programme at the start of their employment that followed nationally recognised standards. During this staff completed dementia awareness training. This gave a basic insight in what dementia was. Nine staff employed had also completed a 'Level 2 Specialist Award in Dementia Awareness.'
Although staff had received training, at times they did not interact or appear to understand how to support people who lived with dementia. A member of staff asked one person who lived with dementia, "X would you like to try this? The member of staff did not give the person the opportunity to respond and placed the item in the persons hand and walked off. Staff sat one person who was blind opposite a person who lived with dementia and who intermittently shouted out. This caused the person who was blind to jump and be startled. The registered manager informed us that staff were being enrolled on more dementia training to enhance their skills and knowledge further.

It is recommended that the registered provider researches and implement's dementia training based on current best practice guidance.

We spoke with staff about the training opportunities on offer. One staff member said, "We have a trainer who provides a lot of it. I've had plenty of training this year." Another staff member told us, "Yes, there is training but I keep myself up to date (using other sources) as much as possible."

Staff were trained in areas that included fire safety, first aid, food hygiene, infection control, moving and handling, safeguarding and health and safety. A training programme was in place that included courses that were relevant to the needs of people who lived at the home. These included dementia care, palliative care, diet and diabetes and wound care.

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions, appraisal and group staff meetings. Staff said that they were fully supported. All of the staff we spoke with told us they had received recent, formal supervision or a yearly appraisal. One staff member said, "The supervision I get is good. I can talk about training and my development." Another staff member told us, "I think it's every couple of months. I can also speak to the manager any time I want."

People said that the food at the home was good and that their dietary needs were met. A relative said, "The food is great. Its food appropriate for their age. They (staff) come round the day before and offer choices. Even X (relative) who has pureed gets a choice. There are always jugs of juice around."

A menu was in place that offered people a variety and choice of home cooked meals, desserts and snacks for breakfast, lunch and dinner. We observed the lunchtime dining experience. Apart from people having to wait too long after being seated for their lunch people in the main received appropriate support based on their individual needs. One person said that they did not want lunch but asked for some soup. This was served and the person asked for bread and butter with it. After asking several times they were told to "be patient." The bread and butter eventually came but their soup was cold and had to be replaced. Other people received support and were offered prompts and encouragement in a positive manner. One relative told us that their family member was eating better than they ever had and was putting on much needed weight.

People's nutritional and hydration needs were well managed. Care plans were in place for managing people's nutritional and hydration needs. Weights were recorded monthly or more frequently if assessed as being at risk. Charts were used to monitor that people identified at risk of malnutrition or dehydration received sufficient amounts of food or fluid. Food supplements' were prescribed to people where needed.

Throughout the day people were offered a range of drinks. Coffee and tea was served mid-morning with biscuits. This eventually included a bowl of fruit but this was not left in the lounge. One staff member was very particular about making sure that people received plenty of cold drinks. Water and juice were available in jugs on the sideboard.

People had access to a range of external health and social care professionals in order to meet their needs effectively. A GP visited the home on a weekly basis and people also had access to out of hour's emergency services. One relative told us, "The doctor comes every Tuesday and we can phone and say we want an appointment any time."

Care plans and assessments were in place for specific health needs. For example, one person had been assessed as being at high risk of developing pressure sores. The person had been provided with pressure relieving equipment. In addition, their nutritional state was monitored regularly and there was an up to date skin integrity care plan in place. External agencies such as the person's GP and dietician were involved; staff followed the advice and guidance provided by these professionals.

Good

Is the service caring?

Our findings

People said they were treated with kindness, dignity and respect. One person said, "I am very happy here. The staff are nice and I have a lovely big room." Two people sitting next to each other agreed that the staff "are very nice." One said they had made friends in the home and "Everyone is very kind." Another person said, "It's early days yet but I'm well looked after and they are very kind."

Relatives also expressed the view that their family members were treated with kindness. One relative said, "The care is excellent, it really is. X (family member) is always clean. They are very kind. If staff can't show it in their vocabulary because their English is not too good they show it in their manor." A second said, "I am happy to go home knowing she is well cared for." A third said, "The home has got a heart." This person went on to say that their family member was treated as an individual.

Staff understood the importance of respecting people's privacy and dignity. Staff were seen to discreetly advise people when they required attention to their personal care and this was always provided in private. People were appropriately dressed. Men were shaved and some women had their hair set. One relative said, "They always make sure X (family member) has their hearing aid in and glasses on." A second relative said, "The care is very person-centred – X (family member) is always clean and tidy."

There was a privacy screen in the lounge that staff used when assisting one person with their medicines. We noted this was not used when staff assisted people to transfer from wheelchairs to lounge chairs using a hoist despite other people being in close proximity. The registered manager told us that this was normally used but that the oversight was due to staff being nervous due to our presence in the lounge.

We asked staff how people's dignity was maintained. One staff member told us, "We try to involve people in their care as much as possible." Another staff member said, "I think it's about all involving them (people)." We did observe staff acting in a fair and equitable manner. For example, we observed a verbal altercation developing between two people. Staff were quick to intervene and de-escalate the situation in a calm, professional and impartial manner.

People were supported to maintain relationships that mattered to them. One relative explained how a member of staff had supported their family member to attend a family wedding. Another relative said that the home had "made a massive visible difference to their lives". They added, "My parents are back as a couple as much as they can be and are as happy as they can be."

We observed care in communal areas throughout the day. Staff took care to ask permission before intervening or assisting people. Consequently people, were seen expressing their needs and receiving appropriate care.

The registered manager had reminded staff about the importance of building relationships with people during a staff meeting held in June 2016. During this staff were told, 'Please interact with people all the time. Explain what you are trying to assist them with whether it be personal care, transferring or at meal times.'

Care plans and records were person centred and securely stored. People's choices and preferences were documented. Care plans contained information about people's personal and social histories and as a result it was possible to see the person in these documents. People and their representatives' were involved in the formulation of their initial care plan. However, we did not find evidence of their formal involvement in care plan reviewing after this. Regular residents meeting took place that encouraged people to express their views and to make decisions about aspects of the service. For example, during the May 2016 meeting people were asked for ideas about events that should take place at the homes annual Fete.

Good

Is the service responsive?

Our findings

People said that staff took appropriate action in response to changes in people's needs. One relative said, "They always let me know if there are problems and call the GP quickly. At the beginning of the year X (family member) was not eating and we thought they were going downhill. They got the GP who prescribed antibiotics. They recovered really quickly."

Care plans contained detailed information about people's care needs and actions required in order to provide effective and responsive care. For example, we noted one person was an insulin dependent diabetic. This meant they were at increased risk of developing a number of related health issues. We noted this person's care plan contained specific guidance and action planning around these issues. The person had been referred for regular appointments with a podiatrist and an ophthalmologist, due to the increased risk of circulatory and visual complications.

Another person presented with certain behaviours from time to time. On these occasions they were prone to verbal and occasionally physical aggression. There was a behaviour plan in place. It contained details of possible triggers to this behaviour and appropriate techniques to be used in the 'de-escalation' of possibly hazardous situations. Staff used these techniques effectively during our inspection in response to the person's behaviour.

One relative told us about an item of equipment that they felt their family member needed. We discussed this with the registered manager who gave assurances this would be acted upon promptly. Within 24 hours of our inspection we were supplied with documentary evidence that the GP was making a referral to an Occupational Therapist in order that an assessment by a suitably qualified person could be undertaken. This would ensure any equipment provided met the person's individual needs.

People said that in the main they were happy with the choice of activities on offer. Everyone was very complimentary about the Fete that the home had hosted in the garden on the previous Saturday. One relative commented that it was "Just brilliant." One person said the fete was "Beautiful." One relative said, "What they put on for them is amazing. They have people in doing sing along, quizzes. The encourage involvement. They had their summer Faye Saturday. X (member of staff) is amazing. He has them throwing bean bags, doing alphabet games, reads local newspapers to them and encourages them to talk."

There was an activity timetable in place that detailed a range of events that people could participate in if they wished. These included visiting entertainers, armchair exercises, reminiscence sessions and games. People said that the activity person encouraged and supported people to participate in events. Holy Communion was advertised for the day of our inspection but when we enquired nobody seemed to know anything about it. We were told later that it had been cancelled as it was a new Vicar and he wanted to attend when the activity person was there.

The home employed a full time activity person but they were not on shift during our inspection. Care staff attempted to engage people in activities but it was clear they did not have the skills and understanding

about how to engage with people who lived with dementia. For most of the day people sat around staring into space or dozing. There was either music playing in the background or a television on but staff did not use either of these to initiate conversations. After the inspection the registered manager notified us that work would be undertaken to improve activities.

It is recommended that the registered person reviews the provision of meaningful activities.

People were supported to raise concerns and complaints. One relative said, "There's a comments book at reception and I can talk to X (registered manager) anytime."

A comments book was located at the entrance of the home in order that people could share their views of the service provided. This included both compliments and complaints. Where a complaint was recorded in the comments book this was cross referenced in the formal complaints log that the registered manager completed. Records included actions taken to investigate the complaint and outcome. These demonstrated that when issues were raised action had been taken to resolve these. For example, when a relative raised concerns about medicines a staff meeting was held and nurses spoken to so that they were aware of the correct procedure to follow.

Information of what to do in the event of needing to make a complaint was displayed in the home. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC.

Requires Improvement

Is the service well-led?

Our findings

People said that the home was well-led and that the registered manager was approachable. One person said, "I like X (registered manager), she's very efficient." A second person said, "Management is very good at LRH." A relative said, "X (registered manager) is brilliant, very approachable and if they are short staffed she mucks in." A second relative told us that the manager had shown their family great support and was a very positive person with a "Can do" attitude.

Despite people speaking positively about the registered manager we found that aspects of the service were not effectively monitored to ensure a consistent, quality service.

A range of quality assurance audits were completed by the registered manager and representatives of the provider to help ensure quality standards were maintained and legislation complied with. The registered manager completed a monthly audit that included checking people's care plans, pressure relieving equipment, moving and handling, wound management, training and supervision and complaints. Where areas for improvement were identified action was taken promptly. For example, the May 2016 audit identified fridge temperature variances. This was addressed before the June audit.

Audits of accidents and incidents including falls was completed monthly. These checked if appropriate medical attention was given, if external agencies including CQC had been notified and if care plans and assessments were updated. Action plans recorded steps to reduce these occurring. However, we found that the action from the May 2016 audit was not being followed. This stated 'To allocate staff to supervise the lounges when residents are in lounge, close monitoring.' During this inspection we observed times up to 30 minutes when there was no staff presence in the small lounge despite people being in there. This had not been identified within any subsequent audit. People did not come to harm as a result of being left unsupervised. However, people lived with dementia and relied on staff for aspects of their care. People were seen sitting, staring around with no stimulation. A staff presence would have enhanced the quality of people's day.

A catering audit was completed in July 2016 that scored this aspect of the service 81% out of 100. There was an action plan form for recording steps taken to make improvements but this had not been completed. The registered manager was able to give examples of some action taken but confirmed these were not recorded.

Six monthly surveys were sent to people and their representatives in order that their views could be used to drive improvements at the home. The findings from these were analysed. As with some of the audits the registered manager had not completed an action plan to address areas identified as needing improvement. She told us of actions that had been taken and there were some records which confirmed aspects of this.

The registered manager said that there was no overall action or development plan that collated the findings from the various audits into one plan to monitor and drive improvements. This was not in line with the provider's quality assurance policy.

It is recommended that the registered person reviews the quality monitoring processes to ensure they are consistent with the provider's policy.

The registered manager was aware of the need to create a positive culture at the home. Everyone that we spoke with said that the registered manager was a good role model. Staff told us that they felt fully supported and that they received regular support and advice. One staff member said, "The manager worked very closely with us. She's close to the relatives too." Records and discussions with staff confirmed that staff meetings took place and people were encouraged to be actively involved in making decisions about the service provided. Where staff raised issues these were acted upon. For example, during a meeting in May 2016 nurses had requested additional training and this had been provided.

Senior management visited the home and people had the opportunity to talk directly to them about the quality of service provided. One relative told us, "The managing director is here on Wednesday. We can book appointments to see and I have." One person who lived at the home told us how they had watched football matches at Wembley stadium courtesy of the provider who had seats there that he offered to people who received a service.

Prior to our inspection the registered manager completed and returned the PIR as we requested. The PIR were accurate and reflected the evidence gained during our inspection. The registered manager understood her responsibilities to notify us of events and occurrences' in the home in line with her legal responsibilities. We had received notifications as required that helped us to monitor appropriate action was taken when incidents occurred.

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 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured that people's rights to consent were upheld, that the MCA 2005 was followed and peoples' legal rights protected. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not sufficient numbers of suitably qualified staff were on duty and deployed at all times to meet people's needs safely and consistently. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.