Buckland Care Limited

The Orchards Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out this inspection over two days on the 5 and 7 January 2015. The first day of the inspection was unannounced. Our last inspection to the service was on 30 December 2013. This was to check the provider had made improvements, which had been identified during a previous inspection in June 2013. The shortfalls were related to people's care, staffing and the management of complaints. In December 2013, improvements had been made and the provider satisfied the legal requirements in these areas.

Summary of findings

The Orchards Residential Home provides accommodation and personal care to up to 44 people, some of whom have dementia. At the time of our inspection, there were 42 people living at the home.

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

Not all risks to people's safety were identified and appropriately addressed. Water from a hand wash basin was hot to touch and a window on the first floor, presented a risk of a person falling from a height. One person at high risk of falling was not supported effectively when mobilising. They were told to sit down rather than find out what the person wanted. There had been a consistent number of falls each month and whilst possible trends had been identified, measures to minimise further occurrences were not effective.

Staff were not always responsive to people's needs. This included one person becoming highly anxious and distressed about being in the home. Another person became louder when vocalising and then became upset. They had soiled their clothing but staff had not identified the signs the person had portrayed. Another person had similarly required assistance to change their clothing.

Not all people received interaction and stimulation from staff. Some staff spoke to each other rather than to people who used the service. A relaxing environment was not consistently maintained. The television was on in the lounge and music was playing in the adjoining conservatory. Both were very loud.

People's care plans were up to date and regularly reviewed although the information was not person centred. The plans did not clearly inform staff of the support the person required or their personal preferences. Some information was conflicting which increased the risk of inappropriate care. Not all staff were consistently documenting people's food and fluid intake if they were at risk of malnutrition or dehydration. This did not enable effective monitoring.

There were some interactions, which were much more positive. This included a member of staff assisting a person to drink. They were attentive and focused on the person. Other staff were friendly and reassuring when supporting people with their anxiety. Staff were aware of promoting people's privacy and consistently knocked on doors before entering.

There were sufficient staff available to meet people's needs. There was a stable team who regularly undertook additional shifts at times of staff sickness. Staff were well supported in their role and received a range of training to enhance their knowledge and skills. An effective recruitment procedure was followed to ensure all staff were suitable for their role.

People were supported to access healthcare services to maintain and support good health. People's medicines were safely managed and administered in a person centred way. There were a range of audits to assess and monitor the quality of the service. People and their relatives were encouraged to give their views and knew how to make a complaint. They felt listened to and were confident any issues would be satisfactorily addressed.

People were complimentary about the meals and had enough to eat and drink. People were offered a variety of foods and could always have something else if they did not like what was on the menu. People's risk of malnutrition was assessed and their weight was monitored. Any concerns were reported to the GP and a referral to the dietician would be made, as required.

We found three 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 the 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

The service was not always safe.

Not all risks to people's safety had been appropriately identified and addressed. Not everyone felt safe due to incidents, which had occurred.

There were enough staff available to meet people's needs. The number of bank staff was being increased to enable additional flexibility with the staffing roster.

People's medicines were safely managed and administered in a person centred way.

Effective recruitment procedures ensured people were supported by suitable and competent staff.

Is the service effective?

Good

The service was effective.

Consent to care and treatment was sought in line with legislation and guidance.

People were assisted by staff who felt valued and well supported. Staff received a range of training to help them do their job effectively.

People had enough to eat and were complimentary about the meals provided.

People received good support from local GP surgeries and other agencies, to meet their health care needs.

Is the service caring?

Requires improvement

The service was not always caring.

Staff knew how to promote people's privacy and dignity, but not all followed this in practice. Some staff did not engage people in conversations but spoke between themselves.

There were positive interactions but some, which could be improved upon.

People and their relatives were positive about the staff team and the care they provided.

Is the service responsive?

Requires improvement

The service was not always responsive.

Staff were not always responsive to people's needs. Care plans were not person centred and did not inform staff of the support required.

Whilst various social activities were arranged, some people received limited interaction or stimulation.

Summary of findings

People and their relatives knew how to make a complaint and felt listened to. Any concerns were quickly and satisfactorily addressed.

Is the service well-led?

Requires improvement

The service was not always well led.

Whilst the number of accidents had been considered and potential trends identified, measures to minimise further occurrences were not effective.

There was a registered manager in post who was responsible for the day to day running of the service.

There were a range of audits to assess and monitor the quality of the service. The frequencies of the audits were in the process of being increased.

People and their relatives were encouraged to give their views about the service provided.

The Orchards Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced on 5 January and continued on 7 January 2016. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In order to gain people's views about the quality of the care and support being provided, we spoke with 16 people and six relatives.

We spoke with the registered manager, a senior manager and six staff. We looked at people's care records and documentation in relation to the management of the service. This included staff training and recruitment records and quality auditing processes.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. 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. The PIR was returned on time and fully completed.

Requires improvement

Is the service safe?

Our findings

One person was repeatedly getting up from their armchair in the conservatory. Staff told them to sit down each time they got up. The person continued to get up and walked gingerly whilst holding onto furniture. One member of staff told us they were at risk of falling if walking unaccompanied. Another member of staff told us the person's walking frame had been taken away, because they had "fallen a lot". The person's care plan and associated assessments gave conflicting information about the support the person required, when mobilising. Actions to minimise further occurrences, indicated the person should use their call bell to request staff assistance. Other information stated the person was not able to do this as they would forget. A call bell was not within the person's reach during our inspection. The registered manager told us they would ensure the person had their walking frame. On the second day of the inspection, the registered manager told us the person had been given a walking frame by their family but had never been formally assessed, as needing one. They said an urgent referral had been made to the occupational therapist to address this. However, previous action had not been taken to address the person's safety.

Not all risks to people's safety had been appropriately identified and addressed. The hot water from one hand wash basin in a person's bedroom was hot to touch. A thermometer showed it was 50° Celsius when the recommended temperature, to ensure people's safety is 43° Celsius. When brought to the attention of staff, the tap was immediately looked at. A fault was noted with the hot water regulator. Staff contacted the plumber and a new part was ordered. A note was posted by the hand wash basin informing the person and staff of the high temperature. On the second day of the inspection, a senior manager instructed the hot water to be turned off, to minimise the risk of harm.

One bedroom window on the first floor did not have a device to restrict its opening. A small table was positioned next to the window. This meant a person could potentially climb on to the table and fall from a height. These risks had not been identified. This was particularly apparent, as one person spent time walking around the home, looking for a way to leave. Once this was identified to staff, the restrictor on the window was repaired.

There were other hazards, which did not promote people's safety. A head board was learnt against a fire door whilst a room was being cleared. This would not enable the fire door to close effectively in the event of a fire. There was a bucket of brown water and a mop in one of the lounges. Due to its prominent position, there was a risk that people could fall over it. A toolbox was located in a bathroom, which people had access to. There was a set of step ladders propped up against a chair in the dining room. As people were entering the room for their lunch, there was a risk the steps would fall against them. There were items such as an odd slipper and Christmas decorations, on the floor. These hazards placed people at risk of harm.

This was a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people told us they did not always feel safe. One person said "sometimes some of the male residents frighten me. Sometimes they are around in the other rooms. I also don't know how to get a carer, when I'm in the conservatory". Another person told us "I sometimes feel frightened when the guys have a tiff". Other people told us they felt safe. Comments included "oh yes, I feel safe in here, because it's England and I have someone to talk to", "I feel safe, as there's always someone about day or night" and "I suppose I feel safe. I'm not frightened of anything". Another person told us "they get a stand aid to move me. It's very comfortable. You can't fall because it has a harness. I feel safe in it". People told us they had never been mistreated or seen anything which concerned them.

One relative was concerned that their family member used the stairs during the night. They said "she has what they call a 'magic mat' but that doesn't stop her. She sometimes has someone else's glasses and slippers. One of the conditions of her staying here was that she would be downstairs". The registered manager told us they were not aware of these concerns but would look into them. Other relatives told us they felt their family members were safe. Comments included "we have no concerns about this home, we come most weeks", "oh yes. We think our friend is safe in here. She spends a lot of time in her room", "I have never seen anything untoward" and "X is very safe and very happy here. The staff are very kind and caring".

Staff were confident about reporting any poor practice or allegation of abuse. They told us they would immediately inform the most senior member of staff on duty. If an

Requires improvement

Is the service safe?

incident occurred "out of hours" they said they would call the registered manager at home. The registered manager told us "I like to be notified about anything so I'm kept informed and I'd always come in, if I needed to". Information about the types of abuse, reporting procedures and contact details, was available to staff in the office. Staff told us they undertook regular training in relation to safeguarding people from abuse.

There were varying comments from people about whether there were enough staff available to support them. One person told us "I don't think there are enough staff. They walk away from me so I've given up asking for anything". Another person said "the staff have no time to chat". Other comments included "yes, there are enough staff about to help me when I need them. I don't wait long", "I don't use the call bell. I wander around looking for staff" and "when they have time they sit and chat, some days are busier than others".

The registered manager told us there were enough staff to support people effectively. They said staff sickness sometimes made cover more difficult, although staff would undertake additional shifts, as required. They said agency staff were rarely used. The registered manager told us they were waiting for a kitchen assistant to start employment and were advertising for a part time cook. They said there were no other staff vacancies although an increase in the number of bank staff would enable greater flexibility with the staffing roster. The registered manager told us there were generally eight care staff plus senior care staff on duty during the day. In addition, there were ancillary staff such as housekeepers, kitchen, activity and maintenance staff. The registered manager told us at night, the home could manage with three care staff although four were better. Additional staff were deployed to support people to attend hospital appointments.

Staff told us there were enough staff to support people effectively. However, there were some comments such as "we could always do with more" and "more would be good but its fine. We have enough".

People's medicines were safely managed. All medicines were stored securely and administered in a person centred manner. Staff dispensed the medicines from a monitored dosage system into a small plastic pot. The pot was then given to the person or the medicines were tipped into their hand, depending on their preference. People were asked if they wanted any pain relief. Staff signed the medicine administration record to show they had given people their medicines. Staff told us they received training in medicines and their competence was regularly assessed. They said there was information available to them, about the safe management of medicines. An audit by the pharmacy who supplied people's medicines had recently been undertaken. No shortfalls were identified. One person told us they were happy with the administration of their medicines. They told us "I always get my medicine when I need it. They don't miss any. I can have painkillers if I want them".

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Good

Is the service effective?

Our findings

The registered manager told us people benefitted from a stable, experienced and knowledgeable staff team. They said staff were committed to their role and willing to learn. The registered manager told us the training offered by the organisation was detailed, varied and relevant to the work each staff member undertook. Staff confirmed this and said the training opportunities within the home were good. One member of staff told us "we are always being offered courses to complete and if we need anything, we just need to ask and they try and arrange it". Another member of staff told us "there's so much training, it's difficult to fit it all in sometimes. They keep us up to date with everything we need to know". Another member of staff told us they discussed their training needs with their supervisor in their supervision sessions. They told us they were encouraged to learn and progress in their role.

Staff told us various formats were used to deliver training. One member of staff told us "we don't just sit in front of the computer or watch DVDs. We often have trainers who come in and do 'face to face' training. It's much more interesting". Another member of staff told us about courses, which were undertaken by the local hospice and mental health team. They said this was really useful, as they were able to discuss particular issues people were experiencing. The registered manager told us staff recently undertook training in relation to dementia care and the management of challenging behaviour. These courses were facilitated by a psychiatrist who regularly visited the home. They said updated training in moving people safely, end of life care and safeguarding was scheduled for the early part of the year. The registered manager told us in addition to day to day topics, staff were encouraged to undertake more in depth training such as Health and Social Care Diplomas.

Staff told us they were well supported by each other and the registered manager. They told us they could raise any issues of concern, at any time. One member of staff told us "the manager is really supportive and makes sure we're ok. They're helped me when I've had issues outside of work. They've been really flexible, which has enabled me to sort things out then come to work". Another member of staff told us "it's like a family here. Everyone gets on well. We've got a good team". Staff told us they had regular meetings with their supervisor to discuss people's care, their work performance, training needs and any concerns they might have. Staff told us the system of staff supervision worked well. One member of staff told us "they'll help wherever they can but they leave you to your own devices. They'll tell you if you've done something wrong but they'll also let you get on with things, which I like".

The registered manager told us staff competencies were being discussed during supervision sessions. They said each staff member's strengths were being developed and support was being given to improve any weaknesses. The registered manager told us in addition, supervision was being used to enhance staff's knowledge in subjects such as safeguarding.

There was a training matrix, which identified the training staff had completed. One member of staff was not identified on the matrix and some recent courses had not been included. The registered manager told us they would update the record and send us a copy after the inspection. This was undertaken. The matrix showed staff were up to date with the majority of their training, which the provider viewed as mandatory. This included moving people safely, safeguarding and fire safety. in addition to the mandatory training, staff had completed additional topics associated with older age, such as nutrition, diabetes and COPD (chronic obstructive pulmonary disease).

Individual personnel files showed one newly appointed member of staff had not received training in fire safety. Another member of staff had not received safeguarding training. The registered manager told us these topics would have been covered in induction and during supervision sessions. They said the staff were also experienced so had completed such training with their previous employer.

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).

Good

Is the service effective?

The registered manager told us they had made various Deprivation of Liberty Safeguards applications and these had been sent to the appropriate local authority. They were aware of those relatives with legal Power of Attorney for both health and welfare and finances. The registered manager told us some people were supported and regularly visited by advocates known as an IMCA (Independent Mental Capacity Advocate). They said they had developed their knowledge significantly in this area due to working with the team. Records showed staff had received up to date training in relation to the MCA. This was being further developed within staff meetings and supervision sessions.

People told us they liked the food and they had enough to eat and drink. One person told us "oh yes, the food is good. You have a choice of two things. We get snacks as well. They bring around biscuits and cakes for us". Another person said "the food is lovely. The chef is French. We get a variety of food. If I don't like something, he will always make me a sandwich". One person laughed as they told us "oh I'm full up, we eat too much and will get so heavy". A relative told us "the food is excellent and I can stay for lunch if I want to. They check X's weight and watch what she eats". Another relative told us "the food is very good here. It always looks nicely presented".

On the first day of the inspection, lunch was chicken or gammon, mashed potatoes, peas and carrots. The meals looked appetising and well presented. Staff told us all food was "cooked from scratch" and the menus were varied to ensure a healthy diet. They said people's medical requirements and personal preferences were catered for. Staff told us people were always offered an alternative if they did not like what was on the menu. One member of staff told us "we try really hard to make sure people have what they like. The food is really good here". They told us people's risk of malnutrition was regularly assessed and people were regularly weighed. Another member of staff told us "if people are losing weight, we always inform the GP and a referral would be made to the dietician if needed". They told us one person preferred to drink supplement drinks rather than other fluids. Due to this, they had asked the GP if their prescription of supplement drinks could be increased. Records showed nutritional assessments and records of people's weight were maintained.

People told us they were able to see health care professionals such as a district nurse or a GP, when required. One person told us "I have many hospital appointments and the manager sorts all my appointments out and arranges transport for me". One relative told us their family member had difficulty hearing and they had been seen by the GP. Two dentists and a GP were visiting people on the first day of our inspection. A member of staff had also accompanied a person to the eye clinic and cardiology department.

Records showed a range of health care consultations had taken place. GPs and the community matron visited people on a weekly basis. This enabled people's health care to be regularly monitored and their medicines to be reviewed. District nurses visited people who required dressings or clinical intervention such as blood monitoring. The registered manager told us staff monitored some people's health, following instructions from the GP. This included testing a person's urine or taking their blood pressure. Staff reported the results to the surgery who advised what further action was required. The registered manager told us this system worked well and often enabled people to start treatment such as antibiotics quickly, without delay.

Requires improvement

Is the service caring?

Our findings

Whilst staff knew how to promote people's privacy and dignity, not all followed this in practice. Some staff talked over people and to each other, without engaging people in their conversations. Two staff had a conversation about needing a holiday, whilst in the presence of a person who wanted to leave the building. Not all staff when walking through the lounges acknowledged or interacted with people.

Some staff placed lunch in front of people, without explaining the contents of the meal. A relative spoke to the registered manager about this, during the inspection. They said "it would be nice if staff told her what she was eating, so she knew before eating it". One member of staff placed a dessert in front of a person. The spoon was positioned on the opposite side of the dish, which meant the person had difficulty reaching it. The member of staff did not show an appreciation of the person's needs. Another member of staff gave a person a biscuit. The person did not recognise what it was, so asked the member of staff. The staff member replied "biscuit" without further comment or pleasantries. This did not show a friendly approach. One person told us they were in pain so we informed the registered manager, as they were in close proximity. The registered manager told us the person had a specific health care condition, which caused them pain. They did not discuss this with the person or check if any pain relief was needed. After the inspection, the registered manager told us the person received pain relief four times a day and they had a pain relieving patch, which was applied to their skin. They said a member of staff had assisted the person to their room and had ensured their pain relief had been taken.

People were positive about the staff although two people said they sometimes felt rushed. They told us "one or two of the carers have not got much patience and they rush me" and "some of the carers are ok, some aren't. They rush around and I have no idea who I am going to get each day". Other people told us "the staff are kind and caring, they are gentle and they talk to me. I have never seen anyone be unkind" and "the staff do listen to me. They are very kind and let me take my time. They discuss my care with me".

Relatives were complimentary about the staff and the care they gave. One relative told us "I can't fault the staff. I visit every day". Another relative told us "there are a couple of staff who just shine. They are lovely and they work wonders with mum. Mum could be agitated and not wanting to see us but X walks into the room and her smile and presence make mum melt. She has a wonderful way of just calming the situation, she's tremendous. We love her". Relatives told us they could visit at any time and were always made to feel welcome. Specific comments included "they always chat to us and we can come anytime" and we are welcome to visit at any time day or night. We came on Christmas Day. I come most days, the staff always welcome me".

There were other interactions, which were much more positive. A member of staff reassured a person who was looking for a family member. They asked the person what time their relative finished work and said "it's not quite that time yet, so they'll be really busy but what about a cup of tea before you go? Come with me and we'll get one, then you'll be ready". Another person was similarly reassured. A staff member told them "I don't like it when you worry. Your family know you're here and that we're taking care of you for a while. If we let you out in the cold and dark, they'd be after us". The person laughed and said "I suppose so". Within both interactions, staff smiled, were attentive and offered their arm to give support and direction. Both people responded in a positive manner and appeared less anxious.

Another member of staff had assisted a person to the lounge. They asked the person if they were comfortable and had everything they needed. They then told the person "I'll see you in a little while. I won't be long". Another member of staff passed a person in the corridor. They said "that's a nice jumper X. It's very sparkly, lovely". One person told us they spent all of their time in bed. They said staff made sure they were comfortable by regularly helping them to change their position. The person had their call bell within easy reach and said they could use it at any time. They said staff always made sure they had everything they needed close by. The person told us "the staff are very nice and thoughtful. They're a nice lot of girls really". Another member of staff assisted a person to drink. They were sensitive, attentive and focused on the person. They asked the person if they liked what they were drinking and regularly checked by asking "I'm not going to fast am I?" and "would you like to carry on or would you like some more later?"

Staff promoted people's privacy by consistently knocking on bedroom doors before entering. One member of staff

Requires improvement

Is the service caring?

knocked and said “it’s only me. I’ve come to do your room. Is that alright? How are you today?” Staff told us they always ensured doors were closed, when assisting people with their personal care. Some staff spoke about people’s feelings and insecurities when receiving personal care. There was an awareness of how difficult this assistance could be for people. Staff told us they ensured people were covered and warm when receiving assistance with personal care. They said they tried to put each person at ease. One member of staff told us “I try to talk to people, as much as I can and let them know what’s happening. It must be really frightening if you don’t understand why you’re being undressed or washed. Being given personal care must be bad enough without not knowing what’s going on”.

Staff told us the best thing about the home was the people in it. One member of staff told us “we’ve got a really caring team who really do care about people”. Another member of staff said “there are some lovely people here, both residents and staff. We’re really lucky. Many of the staff have been here a long time as well, so they’re experienced and good at what they do”. Other comments included “it’s a very small home and family orientated, which attracts people” and “it’s the people that make it. I love coming to work”. Staff told us they became very attached to people whilst working with them. They said it could be very emotional when supporting people at the end of their lives. Staff told us they liked the home’s philosophy of enabling people to remain at The Orchards, if at all possible. They explained this enabled people to die in a homely environment, surrounded by people who cared about them. The registered manager told us “it’s the resident’s home so we always try to keep people if we can. Moving on wouldn’t be right for some people and it would be to the detriment of their health. It’s their home at the end of the day, so if possible, people stay here”.

Requires improvement

Is the service responsive?

Our findings

Staff were not always responsive to people's needs. One person repeatedly walked around the home, shaking doors to get out and becoming more and more agitated and distressed. Some staff tried to reassure and distract the person although other staff did not. The person's agitation increased, as they repeatedly asked staff "let me out please. I need to go home". Some staff told the person "No X, I can't let you out" and walked away. The registered manager told the person they could not let them go out, due to a court order. The person's distress escalated but staff and the registered manager did not respond to this. They did not show confidence in managing the situation. When asked about this, the registered manager told us "it's really hard for the staff. I don't know what to do, so it's not only them. I feel so sorry for X and the torment she's experiencing but what can we do?" We explained the person needed to be seen urgently by a specialised health care professional so that their distress could be more appropriately managed. The registered manager told us they would do this and proceeded to gather information in order to make a referral.

Another person was seated in the lounge and becoming more vocal. Staff passed by the person without interaction or asked them "are you alright X?" without waiting for an answer. The person became upset and started to cry. A member of staff noticed this and gave the person reassurance. They offered to take the person to their bedroom, where it would be quieter. Once standing, the person's clothes were soiled, as they had needed to use the bathroom. It appeared the person had vocalised this but staff had not recognised their need. Another person was taken to their bedroom, also with soiled clothing. The registered manager told us staff assisted people to the bathroom at regular intervals. However, we did not see this consistently during the inspection.

Another person was repeatedly getting up from their chair and at risk of falling. Staff did not ask the person if they were uncomfortable or if there was anything they needed. One member of staff told us the person probably wanted the bathroom but continued to tell the person to sit down, in case they fell. Another person in their bedroom looked uncomfortable in their chair. They were holding their call bell and had food debris on their chest. We asked the person if they wanted staff assistance and used the person's call bell, to request this. A member of staff quickly responded and asked the person if they were alright. They said they would gain the assistance of another member of staff and would reposition them, to make them more comfortable. This intervention was undertaken quickly and in a sensitive manner. Another person asked a member of staff if they could move to another room. The staff member said they would help but did not return to do so. Another member of staff asked a person if they wanted a drink. The person was offered water or orange juice. The person did not answer but the staff member left and then returned with a lemon coloured drink. No explanation was given and the person was not asked if they were happy with the drink.

At 10.30am, the dining room tables had been laid for lunch. Lunch was at 12.30pm. People started to make their way to the dining room, at 12 o'clock. They watched staff walk through the dining room taking meals to those people in the lounges and conservatory. People in the dining room were kept waiting and at 12.50, one person got up and walked off saying, "I'm fed up of waiting". People who had chosen one meal were served first and the remaining people were then served the second choice. This meant people sitting at the same table, were at different stages of their meal. The meal time was chaotic, which did not enable a pleasant, relaxed dining experience.

Some people did not receive staff interaction other than being given their meal or a drink. On both days of our inspection, one person was sat in their wheelchair, at a dining room table. They were next to the television, which was positioned on the wall. The sound of the television was very loud and there was loud music playing in the adjacent conservatory. This did not enable a relaxing environment. Another person spent much of their time, with their head leaning on the arm of their chair. They did not look comfortable and were not supported to change their position. Another person tipped their water from one glass to another. Staff were taking down the Christmas decorations but did not involve people in the activity.

There was an activity board, which showed a range of activities on offer. However, these were not undertaken and people received limited interaction. One person told us they got lonely and did not have enough to do during the day. They said "I sit here most of the time. There isn't much for me to do". Another person told us "my family come some days and that breaks the day up". The registered manager told us the lack of activity was probably due to

Is the service responsive?

the inspection taking place. They confirmed some people had gone to the local pub for lunch and on the second day of the inspection, entertainers had visited. The registered manager told us there were generally "all sorts going on" including regular outside entertainers, arts and crafts groups and theatre groups. The registered manager told us people regularly went out shopping, to local garden centres or for a meal or coffee. They said calendar events such as Easter and bonfire night were celebrated. People were given a small gift on their birthday and at Christmas. The registered manager said there was a range of sensory equipment to engage those people with limited verbal communication skills. This was not seen during the inspection. The registered manager told us an additional activities organiser was looking to be employed to further enhance social activity provision.

People's care plans were up to date and regularly reviewed. However, much of the information was generic and repeated in various care plans. The information was not person centred and specifically related to each individual. For example, in relation to a person's continence, the information stated "check and cream regularly". This did not ensure consistency with the person's support. Another care plan stated "check regularly to ensure he is clean and dry at all times". The information did not inform staff how they were to do this. The registered manager told us people were assisted to the bathroom on a two hourly basis. They said this was an established routine, which all staff were familiar with. They said whilst not fully documented, staff knew the support people required. Other care plans stated "ensure X is checked regularly". It was not clear why, how or how often the person was to be checked. Some care plans identified people's morning and evening routines to manage their personal care. However, there was no information about any intervention required in between. One person's care plan stated "give X time to enable conversation". This was not seen during the inspection.

Within one care plan, it was stated staff assisted the person to drink by using a syringe. An assessment did not identify why this was necessary. Potential risks such as choking had not been identified. The person was supported to eat an ordinary meal. A member of staff did not know why they did not have a pureed meal. They said the person's health had deteriorated and they now spent all their time in bed. The person's care plan had not been updated to reflect this. The person was at high risk of developing pressure ulceration. However, information within the person's care plan did not ensure preventative measures, to minimise ulceration, were sufficient. One person's daily records showed a resistance to personal care. This led to the person being "abusive" to staff. There was no information in the person's care plan to support staff with managing this behaviour.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those people at risk of malnutrition or dehydration had food and fluid charts in place. However, not all charts had been consistently completed. Some records showed people had eaten small amounts of their meal but had not been offered alternatives or regular snacks. Other records showed missing entries, which indicated for example, that an evening meal had not been given. The registered manager told us this was a recording issue. They said staff were very good when offering and encouraging people to eat. They said staff would always ensure people ate something at meal times and if required, would offer something later in the day. Records showed those people that spent the majority of their time in bed, had been given support to change their position. This minimised their risk of pressure ulceration.

People and their relatives knew how to make a complaint if they were not happy about the service. One person told us "now and again I moan and they deal with it". The person was not able to tell us what they had been concerned about. Another person told us "they'd know if I wasn't happy. I'd tell them". A relative told us "the seriousness of the issue would determine who I'd go to. If it was something trivial, I would talk to the care staff but if it was more serious, I'd speak to the manger". Another relative told us they had spoken to the registered manager on the "odd occasion" and things had improved. They told us "the care is lovely here but sometimes it's the attention to detail which could be better". Another relative told us "they're very good here. Once they know there's a problem, they'll sort it". Information in the newsletter, encouraged people and their relatives to raise a concern if they were not happy with the service. The registered manager's email address was stated, to encourage people or their relative to raise a concern electronically.

Requires improvement

Is the service well-led?

Our findings

The registered manager monitored the number of accidents and incidents, which occurred each month. These were relatively high on a consistent basis with 21 unwitnessed falls in December 2015 and 23 in November 2015. An analysis had been completed in relation to when the falls had occurred. This showed in December 2015, 11 falls had occurred between 8am and 6pm and 7 had occurred from 6pm – 10pm. There were 3 unwitnessed falls during the night from 10pm to 8am. Potential reasons had been given for the falls such as a person's health care condition or an infection. However, there was no further action to minimise the number of accidents each month. The senior manager told us they would review this information and would ensure work was completed to reduce the number of accidents occurring. Not all accident reporting forms contained sufficient information to enable effective analysis. This included "found on floor by bed" rather than their exact positioning.

Staff told us there was an emphasis on a homely and relaxed environment. Whilst acknowledging this, some aspects of the environment made it look untidy and cluttered. This included items such as a coat hanger on a hand rail, commode lids on the floor in a bathroom and a pile of bedding on a chair in the corridor. A relative moved the bedding before taking the chair to their family member's room to use. One relative told us "it's like a manic family home here. Very chaotic and disorganised but it has a lovely feel". They said they sometimes felt it would be beneficial for the home to be more organised but they did not want this to change the atmosphere. The environment was not fully conducive to those people living with dementia. Due to the age of the building, there were various corridors leading to bedrooms and communal areas. These were not easy to navigate unless familiar with the building. There was limited signage to direct people. Bedroom doors did not have the person's name or something they could recognise to enable better orientation.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had worked at the home for approximately 16 years it total. They had been the registered manager for six years. They told us they had a consultative management style and were fair and supportive. They said they had an "open door" policy and were always "there for staff". They said they did not want staff to be frightened of coming to the office. The registered manager told us whilst being supportive, they would also address issues as required and had disciplined and dismissed staff in the past. They said they were lucky with the staff team and their qualities, as many had worked at the home for many years and were confident in their role. The registered manager told us there was good progression for staff and they were motivated to learn. They said an initiative, "Employee of the Month" worked well for staff morale. They said people and their relatives were encouraged to nominate staff for this award. The registered manager told us the initiative had enabled staff to be recognised and valued for the work they did.

The registered manager told us they received good support from senior managers. They said there had been a number of changes but they were getting to know the most newly appointed senior manager, who visited the home on a regular basis. The registered manager told us the provider was "brilliant and very supportive". They said they would provide anything people needed, such as furniture or equipment. The registered manager told us they kept up with best practice by attending meetings and training, searching the internet and reading various magazines and journals. They said they aimed to enable an ethos of "promoting independence" and a "homely environment". They were knowledgeable about people's needs and the support they needed.

The registered manager told us they regularly participated within staff handovers, to keep themselves up to date with what was going on. They said they regularly walked around the home to monitor staff practice. One relative however, told us an area of the home, which they thought could be improved upon, would be the registered manager's presence. They said they felt at times, this was limited and greater monitoring of staff practice, would be beneficial. The registered manager did not agree with this view. They said whilst being in the office, they also "watched and listened" to what was going on around them.

There were a range of audits to assess the quality and safety of the service. Many of these had been undertaken on a three monthly basis. However, the new senior manager had stated the audits should be completed more regularly, each month. The registered manager told us this frequency would be adopted in the year ahead. A recent

Requires improvement

Is the service well-led?

audit undertaken by a senior manager identified some shortfalls in various areas. The registered manager told us the visit had been completed when they were on holiday. They said as a result, the senior manager did not have access to a lot of the information and therefore the audit was not accurate. The registered manager told us this had been addressed, when they returned from leave. Other audits showed the service was generally compliant in all areas assessed.

The registered manager told us they regularly undertook visits to monitor the quality of care during the night. They said the visits had never identified any concerns. Records of the visits were sent to the home's head office for monitoring purposes. However, copies of the visits had not been made, so they were not available in the home. The registered manager told us this was an error and offered to gain the reports for use within the inspection. They said in future, such records would be maintained in the home.

People and their relatives were encouraged to give their views about the service. The registered manager told us there was a regular "resident's meetings", which covered topics such as food, laundry, social activities and maintenance. They told us staff met with people who did not attend the meetings in the privacy of their own room. The registered manager told us they were looking to develop the formats of the meetings to include other areas such as staff attitude and competence. They told us they delegated the role of resident's meetings to staff. This was to encourage people to feel comfortable and to be honest when sharing their views. The registered manager told us they sometimes "sat in on the meetings" to ensure the meetings were effective. They said in addition to the meetings, people regularly came to the office to discuss particular issues. More formally, additional feedback about the service was sought by sending out annual surveys. The registered manager told us some people were supported by their relatives to complete these.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Not all risks to people's safety had been appropriately identified and addressed. This included hazards within the environment and the risk of falling. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff were not consistently responsive to people's needs. Care plans were not sufficiently detailed to inform staff of the support people required. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Accidents were not sufficiently analysed to minimise further occurrences. Risks to people safety had not been assured. Regulation 17