Your Health Limited

Langwith Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 28 and 29 July 2016. Langwith Lodge Care Home provides accommodation for persons who require personal care, for up to a maximum of 54 people. On the day of our inspection 33 people were using the service.

A manager was in place and been in post since May 2016. They were not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. An application for the manager to become registered has been received by the CQC. We will monitor the progress of the application.

During our previous inspection on 19 November 2015, we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to; the appropriate application of the Mental Capacity Act 2005, the management of people's medicines and the management of the home.

During this inspection we checked to see whether improvements had been made. We found some improvements had been made, but further improvements were still required.

People told us they felt safe living at the home. Staff understood how to identify and report allegations of abuse. The assessment of the risks to people's safety were carried out, however some of these records required more regular review. Accidents and incidents were appropriately investigated and assessments of the environment people lived in were carried out to ensure it was safe.

The processes for the safe management of people's medicines had improved, but further improvements were required. This included ensuring that the processes where people received their medicines 'as needed' were in place for all and ensuring regular checks of the temperature of the room and fridges the medicines were stored in were also carried out. People and relatives gave mixed feedback about the number of staff in place. We observed an appropriate number of staff to support people, although there were periods of time during the inspection where there was limited staff presence in communal areas.

Improvements had not been made in the way the principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had been followed when decisions were made about people's care. There were very limited examples of MCA assessments having been carried out. There were also insufficient numbers of applications to the appropriate authorising body to legally deprive people of their liberty.

People were supported by staff who had completed a detailed induction and training programme. Some staff required refresher training in some areas. Staff received regular supervision of their work. People spoke positively about the food provided at the home and we observed an organised lunch time experience.

People's day to day health needs were met, but records used to support staff with doing so were not always in place or recorded in sufficient detail.

People were treated with respect and dignity by staff. People felt staff were kind and caring and respected their privacy. People's records contained limited information about their life history; however plans were in place to address this. People were involved with decisions about their care and support needs. People were encouraged to lead independent lives. Information for people on how to access independent advice about decisions they made was available but not easily accessible.

People's care records contained care plans to support staff with providing responsive care. However, these records were often either not fully completed or did not reflect people's current support needs. People and relatives felt the activities provided at the home required improving. We were told by the manager the number of hours the activities coordinator now worked had increased to improve this. People felt able to make a complaint and were confident it would be dealt with appropriately.

The manager's auditing processes had improved since the last inspection, but further work was required to ensure the issues raised within this report were identified and addressed in a timely manner. The manager was aware of their responsibilities to inform the CQC of incidents that could affect people's lives. People, relatives and staff spoke highly of the manager. People were encouraged to become involved with development of the service and were given the opportunity to give their opinions during 'resident meetings' and via questionnaires. However improving people's and relative's awareness of these was needed.

We identified one continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this report.

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.

The assessment of the risks to people's safety were carried out, however some of these records required more regular review.

The processes for the safe management of people's medicines had improved, but further improvements were required.

People and relatives gave mixed feedback about the number of staff in place. We observed an appropriate number of staff to support people, although there were periods of time during the inspection where there was limited staff presence in communal areas.

People told us they felt safe living at the home and staff understood how to identify and report allegations of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had not been made in the way the principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had been followed when decisions were made about people's care.

People were supported by staff who had completed a detailed induction and training programme. Some staff required refresher training in some areas.

People spoke positively about the food provided at the home and we observed an organised lunch time experience. People's day to day health needs were met, but records used to support staff with doing so were not always in place or recorded in sufficient detail.

Is the service caring?

Good

The service was caring.

People were treated with respect and dignity by staff. People felt

staff were kind and caring and respected their privacy.

People's records contained limited information about their life history; however plans were in place to address this. People were involved with decisions about their care and support needs.

People were encouraged to lead independent lives. Information for people on how to access independent advice about decisions they made was available but not easily accessible.

Is the service responsive?

Requires Improvement

The service was responsive.

People's care records contained care plans to support staff with providing responsive care. However, these records were often either not fully completed or did not reflect people's current support needs.

People and relatives felt the activities provided at the home required improving. The number of hours the activities coordinator now worked had increased to improve this.

People felt able to make a complaint and were confident it would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager's auditing processes had improved since the last inspection, but further work was required to ensure the issues raised within this report were identified and addressed in a timely manner.

People were encouraged to become involved with development of the service and were given the opportunity to give their opinions during 'resident meetings' and via questionnaires. However improving people's and relative's awareness of these was needed.

The manager was aware of their responsibilities to inform the CQC of incidents that could affect people's lives. People, relatives and staff spoke highly of the manager.

Langwith Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 July 2016 and was unannounced.

The inspection team consisted of two inspectors and an Expert-by-Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided.

We spoke with eight people who used the service, four relatives, four members of the care staff, activities coordinator, the cook, the kitchen assistant, the deputy manager, the manager and the quality assurance manager.

We looked at all or parts of the care records and other relevant records of 12 people who used the service, as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 19 November 2015 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the management of people's medicines. After our inspection the provider forwarded us an action plan which advised how they would make the required improvements in this area.

During our inspection on 28 and 29 July 2016 we checked to see whether these improvements had been made. We found there had been improvements, but more work was needed.

People told us they were happy with the way their medicines were managed at the home. One person said, "I find them [staff] really good. I have a pain relief patch too." Another person said, "I do the capsules myself."

Previously, we identified that people's medicines were not stored securely within the room where they were stored. The door was not always locked and posed a risk of people accessing medicines that could cause them harm. During this inspection we noted the room was locked and medicines were now stored safely. We saw some improvements had been made to the way topical medicines were managed. A topical medicine is applied to a particular place on or in the body. When these medicines had reached their expiration date, they were no longer used. However, the date of opening of these medicines was still not always recorded. Failure to note the date a topical medicine was opened could decrease the effectiveness of the medicine.

We saw some improvements had been made in relation to the management of people's 'as needed' medicines. These medicines are only used when needed for a specific situation, such as a sudden change in a person's behaviour or increase in pain. Protocols, used to advise staff when to administer these medicines were in place for some medicines where needed, however we found examples where they were not. Failure to have robust protocols in place for these types of medicines could lead to inconsistent administration and increase the risk to people's health.

Improvements had been made in the management of controlled drugs. Controlled drugs have the potential to be misused and have stricter legal controls on their supply to prevent them being obtained illegally. Records were now clearly completed to show when a person had received these drugs.

We noted that checks of the room and fridges where people's medicines were stored had not been completed since May 2016. These checks are important to ensure the effectiveness of people's medicines is not compromised due to too high or low temperatures. We checked the temperatures during the inspection and found them to be within the recommended safe limit.

We raised these issues with the manager. They told us as part of their new auditing process they would ensure that the concerns were rectified immediately and checked regularly to ensure the management of people's medicines was carried out safely.

We observed a senior member of staff administering medicines. They did this competently and safely following good practice guidance. The senior member of staff stayed with the person to ensure they had taken their medicine safely. Where pain relief was prescribed to be taken as required, the senior member of staff was seen to ask people if they required this.

We received mixed feedback from people and their relatives with regards to the number of staff that were available to support them or their family members. One person said, "At the end of the day, the more staff the better but I'm fine with it." Another person said, "They're short staffed this week I can tell. Especially with some on holidays." Another person said, "They're a bit pushed at times."

One relative said, "I visit most days and there always seem to be enough staff around. What I like is that all the staff, doesn't matter what position they have, all help out and support people." However, another relative said, "The staff tell us there's not enough. Sometimes they look like they're running ragged or get used helping in the kitchen. I think they have agency at night." Another relative said, "Afternoon seems to be thin on the ground."

Staff told us there had been changes made to staffing levels and whilst this was good they still felt rushed at particular times of the day. One staff member told us, "I feel that we are rushed a lot, I feel terrible when someone requests assistance and I have to say 'in a few minutes' and then it's easy to forget." Another staff member said, "We very rarely get breaks on time and we're completing records in an afternoon for the morning, so the detail can be missing as it's hard to remember things."

We observed that staff responded on the whole in a timely manner to people's support needs. However, we saw that staff were not always present in communal areas. This was a concern because most people were living with dementia and relied on staff to ensure their safety and meet their needs. We concluded that there were sufficient staff on duty but the deployment of staff could have been better. There lacked clear organisation and leadership from staff responsible for the shift. We discussed this with the manager who agreed this was an area they had identified as requiring improvement. They said that new senior staff had recently been appointed and they were planning training in terms of communication and leadership skills.

Safe recruitment procedures were in place. Checks on staff suitability to carry out their role before they commenced work were carried out. This included checks to establish whether a potential member of staff had a criminal record, whether they had sufficient references and proof of identity. This reduced the risk of people receiving care and support from unsuitable staff.

People told us they felt safe living at the home. One person said, "I'm very safe, the team make you feel like that." Another person said, "Yes, I do feel safe, I love it here." Another person said, "Oh yes, I do feel safe but I do get people wandering in sometimes [person's bedroom]. They are probably looking for the loo." A relative said, "[My family member] is absolutely safe. [Name] came in again last week on respite and has asked us to let them stay now."

Staff demonstrated a good awareness of how to protect people from avoidable risk. They knew the different categories of potential abuse and what their responsibilities were if they had concerns about a person's safety. One staff member told us, "We're aware of signs to look for such as a change to a person's normal behaviour and unexplained bruising would be a concern." Another staff member said, "We have procedures we have to follow if we have safeguarding concerns, we record and report it to our senior, and the manager contacts the safeguarding team and CQC."
Some people who used the service were living with dementia; we observed how staff responded sensitively and reassuringly when people became anxious. They were aware about protecting the person and others

from harm.

Staff gave examples of how they supported people with known risks. One staff member said, "Some people need staff to support them with their mobility. This might be assistance from staff or equipment such as a hoist." They added, "We're also aware about making sure the environment is safe from trip hazards and if people have a walking frame they are kept by them."

We found from people's care records that where risks associated to people's needs had been identified, appropriate action had been taken to reduce and manage these risks. Staff gave examples of action taken such as an external door being alarmed. This was due to a person leaving the building who did not have the mental capacity to safely access the community independently. We saw that this door sounded an alarm when it was opened and staff responded to ensure people were safe. Staff gave examples where restrictions were not unnecessarily placed on people. One staff member said, "[Name of person] goes in and out independently, they enjoy being in the garden."

Where people required equipment to manage risks we saw these were in place. For example, some people required pressure relieving cushions to support their skin, other people were at high risk of falls and had assisted technology such as sensor mats to alert staff when they were mobile. Whilst care records showed risks had been assessed and planned for, these were not routinely monitored for changes. For example, one person's care records showed their care and risk plans had not been reviewed since they moved to the service in May 2016. This is important to ensure staff have up to date information about people's current needs.

Regular reviews of accidents and incidents that occurred at the home were carried out. Where trends or themes had been identified, preventative measures were put in place to reduce the risk of reoccurrence.

People had individualised personal emergency evacuation plans in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. A business continuity plan, which outlined how people would be protected in an emergency, was also in place and available to staff. Records showed regular servicing of the lift and other equipment such as hoists, walking aids, gas installations and fire safety and prevention equipment were carried out to ensure they were safe to use.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection on 19 November 2015 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to principles of the Mental Capacity Act 2005 not being followed when decisions were made for people. This also included the process for ensuring people's liberty was not illegally deprived. During this inspection we checked to see whether improvements had been made in this area. We found they had not.

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. We checked whether the service was working within the principles of the MCA.

People told us staff always asked for their consent before providing care or support. One person said, "They always ask what I'd like to do before helping me." Another person said, "They always ask me and so nicely." Another person said, "They're lovely at asking me if I'm ready."

The staff we spoke with had a basic understanding of the MCA and DoLS. A staff member told us, "People's capacity to consent to a specific decision has to be assessed." Another staff member said, "I know we can't restrict people without being authorised to."

People had their needs assessed prior to moving to the service but the pre- assessment we saw did not show that people's mental capacity to consent to their care had been considered. We did note that the pre-assessment considered if a person had a lasing power of attorney (LPA). This gives another person legal authority to make decisions on behalf of another person relating to either a person's finances or care and welfare decisions. However, we found this was not always recorded. We discussed what we found with the manager. They told us that the pre-assessment document was in the process of being reviewed. They also said that they were aware of the importance of seeking confirmation if a person had a LPA.

We also found no mental capacity assessments had been completed for people. This included people where it was clear from their care records, that there were concerns about their ability to consent to some decisions due to health conditions they were living with. The quality assurance manager showed us one undated mental capacity assessment that had been started but not completed. We noted that one person's relative had signed a form that showed they had given consent on behalf of their family member for a variety of decisions. However, when we discussed this with the quality assurance manager it was identified that this person had no LPA in place that gave the relative legal authority to consent on their behalf.

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 are called the Deprivation of Liberty Safeguards (DoLS). We looked at the documentation for three people and found staff adhered to the terms of the DoLS.

We asked the manager to confirm whether there were people living at the home whose safety would be at risk if they were to leave the home attended. They told us there were. We noted the doors to the home were locked and could only be opened with a code. Records showed that whilst applications to the authorising body had been made for some people, they had not been for all that required. This meant that some people's liberty may have been deprived.

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

We saw examples of do not to attempt resuscitation orders (DNACPR) in place. These had been completed appropriately. We saw a person had an advance decision plan in place. This meant that staff had important information available about people's decisions for their end of life care needs.

People told us, and records viewed confirmed, they had access to external health care professionals when they needed it and they felt their day to day health needs were being met. One person said, "The nurse comes in to do my leg dressings." Another person said, "The staff spotted when I was poorly and got the doctor. The chiropodist comes to see me and the hairdresser is very good." A relative said, "[My family member] just got new specs from here and has got an appointment for a new hearing aid."

The quality of the care records used to monitor people's day to day health needs was variable. Staff told us that they found information was limited in parts. One staff member said, "I don't always find people's records are detailed and when changes occur the care plans are not always updated."

We found care plans lacked detail. For example we saw a person had been identified as at risk of developing a pressure sore. Their care plan stated they were to be 'monitored regularly', but gave no indication of the frequency that this should occur. This increased the risk of the person receiving inconsistent care and support from staff. Another person's records stated cream that should have been applied twice a day to their skin. Whilst the cream was available in the person's bedroom there was no care plan in place to instruct staff of this. Records did not show that this cream had been applied as required.

People told us they were happy with the effectiveness of the staff support. One person said, "They're a damned good team." Another person said, "They keep a good eye on me. I trust them all." Another person said, "I think they're excellent. Although some are better than others." Relatives also spoke positively about the staff. One relative said, "They're very well trained." Another relative said, "I think they deal with things well."

We viewed the provider's training matrix, used to record when staff had completed their training and also to identify when training needed to be renewed. Records showed that some of the training was up to date, but further refresher training was needed for staff in some areas. These included moving and handling, fire and food safety. The manager told us they were aware of the gaps in the training and would ensure staff completed the training as soon as possible.

Staff spoke positively about the induction, training and support provided. Some staff had recently started working at the service; they said they found the induction useful. One staff member said, "The induction and shadowing of staff was really helpful. The manager has been very supportive, I feel I've fitted in well, the team are good." They also said that they had meetings with the manager during their probationary period to review their work. Other staff members said they received opportunities to meet with the manager on a one to one basis to discuss their work and training needs. Records showed staff received supervision of their work to enable the manager to be confident they were carrying out their role effectively.

People spoke positively about the food and drink provided at the home. One person said, "I can't fault it. I can think of no complaints, they deserve every compliment. I had a fry up for breakfast and it was lovely." Another person said, "It's quite nice. They did me a special yesterday, jacket potato and salad as I didn't like the menu. They do snacks too, as the other day I really fancied a jam sandwich in the evening and they made it for me." Another person said, "It's very good food. It comes hot. Although they do bring me too much sometimes." A relative said, "It's lovely food. I see them give [my family member] a choice and support them with eating."

Staff we spoke with showed a good understanding of people's nutritional needs and preferences. The cook told us how they provided appropriate meals for people with diabetes and how some people required their meals presented in a particular way due to concerns identified with swallowing. The cook also said that some people required their food to be fortified to provide an increase in calorie intake due to concerns related to the risk of malnutrition.

We found care records showed people's dietary and nutritional needs had been assessed and planned for. This included consideration of people's cultural or religious needs in association with their diet. People's food likes and dislikes and preferred portion size was also recorded. These needs were known by staff including kitchen staff.

Some people had been assessed as being at risk of malnutrition and had been referred to external healthcare professionals such as their GP or dietician. Where people had been prescribed food supplements, we saw these were available and records confirmed people had taken these as required.

We observed lunch being served. We were told by a member of staff that the time of lunch for people lasted two hours in order to support people to eat when they wanted to. People received their meals in a timely manner. Where people required assistance with eating their meal, staff supported them appropriately. People received meals that were personalised to their preference and people appeared to enjoy their meals. We did note that a menu was not available in the dining room.

We saw people received regular drinks during their meals and also throughout the inspection. One person said, "I can have as much as I want. I've got my water jug and ring for tea when I want it."
Another person said, "We get tea, juice, milk or anything we want." A relative said, "[My family member] needs to have drinks given to them and held, I think it's done but I don't know. At home they often had urine infections but they are ok so far here."

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring and they enjoyed living at the home. One person said, "Nothing is too much trouble. Yesterday I said I really fancied a KitKat, and today one of the lasses brought me some in. So kind." Another person said, "They're definitely kind." Another person said, "They're all lovely." Relatives also found staff kind and caring. One relative said, "All the staff including the cook and cleaner are lovely." Another relative said, "In general, they're fine, but we did have an issue with one member of staff recently."

We observed staff and people interact with each other positively throughout the inspection. Staff used a variety of communication skills that enabled them to understand people. Staff listened to what people had to say and used people's preferred name and terms of endearment. People responded positively to this. Staff gained people's eye contact when talking with them, gave explanations and choices and waited for people to respond. One staff member was heard to say to a person, "That's a lovely smile you've got this afternoon." The person responded positively showing they were happy with the comment made.

We noted staff were busy throughout the inspection, but when they passed by someone in a corridor or when they walked into a room, they ensured they acknowledged people and said hello. Staff also responded when people were showing signs of discomfort. For example, a staff member recognised a person was struggling to cut their food up at lunchtime. They offered to do this but were sensitive in their approach and mindful not to take the person's independence away.

People told us staff supported them to remain as independent as they wanted to be. One person said, "I decide what to do, not them." Another person said, "I get lots of independence, I'm still alright up top." Another person said, "We can choose food and drinks. I decide on my clothes for the day, they ask me."

We observed staff respect people's choices. For example, when a person expressed a wish to sit at another table the staff member supported them in doing so. During the lunchtime meal, staff were respectful of people's wishes. We observed staff ask people if they would like an apron to protect their clothes whilst they ate. Where people refused, staff respected their choice.

Information was available for people about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. However this information was not easily accessible due to it being located in the foyer behind a locked door.

People told us they were involved with decisions about their care. One person said, "They [staff] have to involve me as I ask them and they keep me updated. " Another person said, "They [staff] ask me questions to go in my care plan." Another person said, "Sometimes they'll talk it through with me." A relative said, "We've a meeting today with the manager and social worker about [my family member] staying here full time and the finances."

The staff we spoke with were knowledgeable about people's needs, routines and what was important to them. However, we found in people's care records that information about their life histories and preferences were variable in terms of detail. We saw examples where a document called; 'All about me' provided staff with information about a person's life history. This was then used to develop care plans to advise staff of what their routines and preferences were. The manager acknowledged that this information was lacking in some people's care records. They said that the activity coordinator had plans to work with people and their relatives, to develop a better understanding of people's life history. This meant that the provider was exploring ways of developing a better person centred approach to the care and support provided to people.

People told us they were treated with dignity and staff respected their privacy. One person said, "They're so good and will knock even though the door's open." Another person said, "They knock and wait for me to say come in. The girls I tell to just come in as often they're carrying something, but the men have to knock." Another person said, "They always wait for me to say come in."

Staff gave examples of how they respected people's privacy and dignity. One staff member said, "We knock on people's doors before entering, I treat people how I would want my family member treated."

The registered manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed and spoke with relatives visiting people throughout the inspection. A person living at the home said, "They can come any time to me." A relative said, "I come all sort of times but mainly the mornings. It doesn't matter when."

Requires Improvement

Is the service responsive?

Our findings

People told us they wanted more activities to be provided for them. One person said, "I mostly watch TV from my chair. No-one comes up for a chat unless it's family." Another person said, "I like my own space. They'll still ask me if I want to go on an outing. I was with the Salvation Army, I'd like to see them but they don't know I'm in here." Another person said, "I like the bingo. We had a trip to Skegness last year but it sounds like we won't be getting another long trip now." Another person said, "I like the baking and I join in most things. I do get bored so will just watch TV in my room."

Relatives also raised concerns about the lack of activities at the home. One relative said, "[My family member] sits beside the front door and watches all that's going on. This is where I have a concern; I don't see any activities taking place. I've been here when musicians have been on but on a day by day basis, there's not enough." Another relative said, "[My family member] is always put in the same place in the foyer and just sits and watches."

However, one person praised the staff when they had asked them to support them with something that was important to them. They told us their family had been given permission to set up some gazebos outside their bedroom and set up a BBQ for a family party. Staff were also invited.

We spoke with an activity coordinator who told us that their hours had recently increased and that they worked flexibly including some weekends. They told us that they developed a weekly activity timetable based on what people requested to do and was based on known interests. They said, "I ask people what they would like to do or will provide activities and if they are not popular I'll try something else." They added, "Not everyone wants to join in activities, so I spend one to one time with people chatting about things of interest to them."

In the reception area was a large tropical fish tank. Staff told us that the day before our inspection two people asked if they could go and get some more fish which they were supported to do. The activity coordinator gave an example of how they supported a person who asked if they would take them to the local pub for a meal as they disliked being in a group. Another person had specifically asked the activity coordinator to go shopping with them which they did.

We saw the activity co-ordinator playing dominoes in the dining room with four people who had the capacity to play the game. People sat in the main lounge and had a television to watch, although with the layout of the room, six out of ten of them were unable to see the screen. There was no television in the small lounge where four people were sat. We also noted that the activity co-ordinator spent some of their time helping with care; taking people back to their room or settling them in a lounge and assisting people with eating their meals at lunchtime. These tasks could impact on their availability to support people effectively with their hobbies and interests.

We discussed activities with the manager. They told us they had acknowledged that the lack of activities for people had previously been an issue, and had recently secured extra funding to increase the activities

coordinators hours from nineteen to thirty hours per week. They told us they hoped this would improve the experience for people living at the home.

People had a pre-assessment of their needs completed before they moved to the service. A relative confirmed that the manager had visited their family member in hospital to assess their needs. This information was used to develop a 72 hour care plan as an initial support for staff, and then further more in depth care plans were developed.

We found the quality of care plans varied in the level of detail provided for staff. For example, a person's pre-assessment stated that they had a particular health condition and had reoccurring water infections. There was no information to advise staff what this meant for the person and what was required of them.

In a further care plan a person was described as requiring two staff with bathing due to becoming 'aggressive'. There was no further information to advise staff what they needed to do to support this person, such as behavioural strategies to use. We asked a staff member about this and they said they were not aware of this concern and supported the person by themselves without experiencing the person becoming anxious. This meant that staff were either not fully aware of people's needs or the records were not reflective of people's current support needs. This may impact on people receiving an effective and responsive service.

People told us that they felt involved in discussions and decisions about how risks associated to their needs were managed. One person told us that they had bed rest in an afternoon as a way of reducing their skin from developing pressure sores. This person was not mobile and required repositioning to protect their skin. We spoke with this person on the morning of our first day of our inspection. They said they were feeling uncomfortable but would be having bed rest shortly after they had eaten. We saw that this person had visitors in the early part of afternoon for a short period and at 3.45pm they were still sat in their chair. We were concerned that this person had not had their bed rest as assessed as required which could have a negative impact on their health. We discussed this with the deputy manager who arranged for the person to go to their bedroom.

The quality assurance manager told us they had overseen a review of the quality of the care records and a new care planning system had started to be used in the home. These new records were based on people's needs, routines and preferences and enabled staff to provide a personalised and responsive service. However, the care records of new people to the service provided staff with limited detail of their needs. This told us that whilst the provider was improving the standard of information recorded about people's needs, this remained an area that required further review and improvement.

We noted that people's care records did not always clearly demonstrate how they were involved in reviews of the care and support they received. However, the people we spoke with did feel they were involved with decisions about their care. The manager said that they were aware of the need to ensure people's records accurately reflected their involvement with decisions and had plans to do this.

People and relatives told us they were satisfied that if they made a complaint that it would be handled appropriately. One person said, "I've never made a complaint at all." Another person said, "I did have concerns about some food recently, I sent it back as it was stone cold. But things are usually hot now." Another person said, "I haven't had to complain. If I did, I'd talk to [name of staff member], but most of the others are kind too." Another person said, "[My relative] complained for me and it's fine now." A relative said, "I'd have words with the manager if I had a concern." Another relative said, "I'd just go straight to the manager."

People were provided with a complaints policy within their service user guide when they came to the home. A complaints policy was also provided. However, this policy was unsuitable for people with communication needs. Additionally the positioning of the policy would make it inaccessible for many people.

We viewed the complaints register and saw the registered manager had ensured that when a complaint had been made this was dealt with quickly and people were responded to in a timely manner, and in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection on 19 November 2015 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the management of the service and the lack of robust quality assurance procedures to identify, assess and reduce the risk to people's health, welfare and safety. After our inspection the provider forwarded us an action plan which advised how they would make the required improvements in each of these areas.

During our inspection on 28 and 29 July 2016 we checked to see whether these improvements had been made. We found there had been some improvements, but further improvements were needed.

We reviewed the provider's action plan, sent to us after the previous inspection, which included self-imposed deadlines by which the provider had assured us the required improvements would be made. We found that whilst some of these deadlines had been met, others, such as the application of the Mental Capacity Act, showed little progress. We raised this with the quality assurance manager and the home manager and they agreed that further progress should have been made.

The manager showed us the new quality assurance processes that were now in place to assist them in ensuring the service provided for people was safe. Audits that were now in place included, regular monitoring of the environment in which people lived, people's medicines and staff performance. However, the manager acknowledged that there was still more work to be done to ensure they were carried out consistently and effectively to identify and sustain improvement within the home. For example, key areas of people's care needs such as ensuring medicines were appropriately managed and the failure to appropriately apply the principles of the Mental Capacity Act 2005 had not been identified during these audits.

People told us they felt there was a positive atmosphere at the home. One person said the atmosphere was, "Brilliant." Another said, "It's very nice." A relative said, "There's no smell and it doesn't feel like an old place." Another relative said, "It's a homely atmosphere. A pleasant place."

Staff also spoke positively about the home and they liked the team they worked in. One staff member described the staff team as, "Friendly, we get on well together and are hard working." Our observations throughout the inspection confirmed what people, relatives and staff had told us. People appeared at ease in each other's company which resulted in a calm atmosphere at the home.

We received mixed feedback from people and relatives when we asked them if they had been involved with decisions to develop the service. Some told us they had received questionnaires or had been invited to 'resident or relatives' meeting, whilst others told us they had not. One person said, "I've not heard of any surveys or meetings for us." Another described the offer of meetings and questionnaires as, "News to me!" However another person said, "If any of us [people living at the home] bring up anything, we are listened to." We also received mixed feedback from relatives. One relative said, "There's a meeting the first Tuesday in each month, I turned up to the last one but they'd changed the time so I missed it. It'd be helpful if they'd

email the minutes if we can't get there." Another relative said, "I've heard there's a monthly meeting. We've not had any survey or requests yet."

We spoke with the quality assurance manager and asked them how people were encouraged to become involved with developing and improving the service. They told us questionnaires had recently been sent out but they had not yet provided people with the results nor a plan to address any required improvements. Records showed the results of the questionnaires had been received in March 2016. This meant there had been a four month period where people and relatives had not been informed of the outcome. However, when we reviewed a sample of these questionnaires, we saw the majority of responses were positive. These included comments about the environment, quality of care and the food.

The staff we spoke with told us they felt supported and involved with decisions about how to improve the service. They also felt the new manager to the home had started to improve the service.

All staff spoke positively about the manager, whom they described as, "Approachable, supportive, firm but fair and a good leader." One staff member said, "The manager is brilliant, prepared to listen to you and gives praise where due." Another staff member told us, "The manager is making a difference, they do a walk around in the morning and afternoon, they are more aware about what's happening."

People and relatives also spoke positively about the manager. One person said, "She came and served tea the other day when they [staff] were busy." Another person said, "She gives me a hug if she pops her head in. I can easily talk to her. You can't ask for a better manager." Another person said, "I see her now and then to say hello, I could talk to her if I had to." A relative said, "I love her to bits, she's very easy to talk to."

It was clear from talking with the manager that they had a clear vision of how they planned to make the required improvements at the home. They spoke passionately about the people they and their staff cared for. They told us they planned to give staff more responsibility and 'lead roles' to help to develop their skills. These included staff specialising in dementia awareness, dignity, tissues viability and infection control. They felt this would improve the quality of care people received, but would also reassure staff that they were a valued and important part of the team.

As many of the manager's plans were not yet in place or had not been in place for sufficient time, we were unable, yet, to judge whether they were effective or sustainable.

The registered manager told us they were aware of their responsibilities to meet the conditions of their CQC registration. The CQC must be informed via a statutory notification if a person receives a serious injury or if they were being deprived of their liberty.

Staff told us they would be comfortable raising issues using the processes set out in the whistleblowing policy. They felt that management would take action if any serious concerns were raised with them.

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 did not always ensure; (1) Care of service users must only be provided with the consent of the relevant person. (3) where a service user is 16 or over and unable to give such consent because they lack the capacity to do so, the registered person acts in accordance with the 2005 Act.