M & J Care Homes Limited

Lyme Bay View Residential Home

Inspection report

Old Beer Road
Seaton
Devon
EX12 2PZ

Tel: 0129722629

Date of inspection visit:
10 May 2016
19 May 2016

Date of publication:
29 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 10 and 19 May 2016. The first day of our visit was unannounced. Our second visit was announced so that arrangements could be made for us to spend time with the provider, registered manager and manager.

Lyme Bay View Residential Home is a care home providing personal care to a maximum of 30 older people. They provide care and support for frail older people and those people living with dementia. The home is a detached house near the town of Seaton in the coastal area of East Devon. On the first day of the inspection there were 23 people staying at the service, which included one person staying for a short stay referred to as receiving respite support.

We carried out an inspection of this service in August 2014. One breach of legal requirements regarding recording keeping was found. We returned in October 2014 and undertook a focussed inspection to check whether the requirement had been met. We found that the service was then meeting the requirement.

Several people at the home had a dementia type condition and we were unable to fully explore their experience of care and support through conversations. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them.

One of the provider's representative's is also the registered manager of the service. They had decided to step down from this role and had submitted their application to deregister with the Care Quality Commission (CQC). A registered manager is a person who has registered with 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. The registered person had appointed a manager to manage the service. They were in the process of completing their application with CQC to become the registered manager at the service. The manager had been at the service for six months at the time of our visit. They were very visible at the service and undertook an active role. They were very committed to providing a good service for people in their care and demonstrated a strong supportive approach to people, their relatives and staff. They were supported by the provider's representative who worked at the home each day and the registered manager.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. The staff and manager undertook additional shifts when necessary to ensure staff levels were maintained. When gaps were not able to be covered agency care workers were used.

The manager demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. They understood that where people lacked capacity a mental capacity assessments needed to be completed and best interest decisions made in line with the MCA. They had recognised that mental capacity assessments had not been undertaken and were in the process of implementing new documentation. They were working with the local authority Deprivation of Liberties Safeguarding team

(DoLS) to make appropriate applications to deprive some people of their liberties. Staff had a good understanding about giving people choice on a day to day basis and had received MCA training to help them understand their responsibilities.

People were supported by staff who had the required recruitment checks in place although there was not a clear system to ensure all checks were completed. Staff had received a basic induction. Not all staff had completed the provider's mandatory training. The manager had recognised this and was working to ensure all staff had undertaken the training and a more thorough induction. They had helped a few staff enrol onto courses of higher qualifications in health and social care. The three senior care workers we spoke with were knowledgeable about the signs of abuse and how to report concerns. However only half of the staff had completed training in safeguarding of vulnerable adults.

People were supported to eat and drink enough and maintained a balanced diet. We had concerns that the monitoring of people's diet and fluid intake was not being managed effectively. The manager put in place new fluid monitoring charts with an improved oversight of the amount of fluids people received. People and a visitor were positive about the food at the service.

People said staff treated them with dignity and respect at all times and in a caring and compassionate way. People received their medicines in a safe way because they were administered appropriately by suitably qualified staff. The manager had worked with the local pharmacist and put in place effective procedures and auditing.

People had access to activities at the service. People were encouraged and supported to develop and maintain relationships with other people at the service to avoid social isolation.

People's needs and risks were assessed before and on admission to the home. Risk assessments were undertaken for people to ensure their health needs were identified. Care plans reflected people's routines and wishes. However they were not updated with people's changing needs. On the second day of our visit a new care file format had been put into place with more detailed care plans. These gave staff guidance about how to support people safely. The manager said these would be reviewed on a monthly basis or as people's needs changed. People were involved in making decisions and planning their own care on a day to day basis. People said they were referred to health care services when required and received on-going healthcare support.

People were at risk of accessing chemicals. This was because they were stored in a cupboard which had a sign stating it should be locked. On two occasions the cupboard was not locked. We have made a recommendation about the safe storage of chemicals at the service.

The home had a homely atmosphere with no unpleasant odours. The premises were well managed to keep people safe. The provider had been undertaking a major refurbishment of the house, redecorating corridors and communal areas and replacing some windows.

The provider had a quality assurance and monitoring system in place. This included regular audits and annual surveys for the provider to assess the effectiveness of the service provided. The manager actively sought the views of people and staff through regular meetings. There was a complaints procedure in place which the provider was updating to reflect other outside agencies staff could contact. The manager had a clear understanding of how to respond to concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some areas of the service were not safe.

The premises and equipment were managed to keep people safe. However risks to people had not always been considered and actions taken to keep them safe.

People said they felt safe. Senior care workers were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised. However only half of the staff had completed training in safeguarding of vulnerable adults.

Improvements had been made to ensure people's medicines were being managed safely.

The provider and manager ensured staff levels were adequate to meet people's individual needs.

There were effective recruitment and selection processes in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received the provider's mandatory training. The new manager had identified this and was taking action to fill any training gaps.

Staff were seen to be confident in meeting people's needs.

Staff had received a basic induction and had regular supervision. Some staff were undertaking higher health and social care qualifications. The manager had scheduled appraisals with staff.

People's health needs were managed well through contact with community health professionals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). The manager was working with the DoLS team to make

appropriate applications. They were also putting in place mental capacity assessments to ensure people's rights were maintained.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Visitors were encouraged and always given a warm welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans were person centred about people's histories, wishes and social need. However they did not reflect people's changing health needs and guide staff how to appropriately meet those needs. The manager had an action plan that new care plan documentation would be in place for all people at the home by the end of June 2016.

A designated activity person supported people to undertake a range of activities. The cook also undertook additional hours to provide activities at the home.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not always well led.

The new manager at the service had recognised there were areas that required improvement. They had put together an action plan to address these concerns.

Staff spoke positively about communication and how the manager and owners worked well with them.

People's views and suggestions were taken into account to improve the service.

There were audits and surveys in place to assess the quality and safety of the service people received.

Lyme Bay View 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 was planned to check whether the provider was 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.

Lyme Bay View Residential Home is a care home providing personal care to a maximum of 30 older people. The service is intended for older people, who may have a dementia or mental health need. On the first day of the inspection there were 23 people staying at the service, which included one person receiving respite support.

This inspection took place on 10 and 19 May 2016. On the first day an adult social care inspector was accompanied by a CQC National Safeguarding Advisor. They were there to observe the new inspection process. On the second day the adult social care inspector completed the inspection.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which we received in April 2016. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

We met and observed most of the people who lived at the service and received feedback from seven people who were able to tell us about their experiences. Several people at the home had a dementia type condition. A few people using the service were unable to provide detailed feedback about their experience of life at the home. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We also spoke with a visitor to ask their views about the service.

We spoke and sought feedback from seven staff, including the manager, senior care workers, care workers, the cook and housekeeper. We also spoke with the registered manager and the registered provider.

We reviewed information about people's care and how the service was managed. These included three people's care records and four people's medicine records, along with other records relating to the management of the service. Such as staff training, support and employment records, quality assurance audits, and minutes of team meetings. We contacted the local authority safeguarding team, health and social care professionals and commissioners of the service for their views. We received a response from two of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and were happy at the home. Comments included, "I am very happy here, I feel safe… not too bad" and "Yes very safe we had an alarm (fire alarm) yesterday for a practice."

Staff and a visitor also said they felt the service was safe. The visitor commented, "I have no worries regarding (person) being safe." A care worker said, "My residents are safe, a lot of things have changed here…they are safe, if they want something we try to fix it for them."

People were not always protected because risks for each person were not identified and managed. The environment was safe and secure for the majority of people who used the service and staff. However on the first day of the inspection we found two windows on the first floor of the home without window restrictors in place, which had openings above the 100 millimetres maximum as recommended by the Health and Safety Executive (HSE). This meant vulnerable people had access to window openings large enough to climb through and fall out of, at a height that could cause them harm. The provider explained that these were two newly installed windows and that they were aware of the problem. They said the installer had brought the wrong restrictors when installing them and the correct ones were on order. The manager had not assessed the risks for the two people using the rooms and taken measures to make them safe. However on the second day of our visit the window installer had put window restrictors on both windows.

A cupboard containing cleaning chemicals was found on both visits unlocked. The cupboard had a sign saying it should be locked when not in use. We observed a person who would not recognise the risk to themselves trying to access the cupboard. A care worker came along and distracted them and locked the cupboard. We discussed this with the provider and manager and they said they would remind the housekeeping staff to keep the cupboard locked at all times.

We recommend that the service consider current guidance on the Control of Substances Hazardous to Health (COSHH) at the service and take action to update their practice accordingly.

Records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin damage, nutrition and handling assessments. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. People assessed as being at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs. Risk assessments had also been completed regarding people's rooms which included the furniture and equipment. However people were not always protected from risk.

People received their medicines safely and on time. The manager said they had recognised the medicine management at the home had previously not been safe. They had made changes and had worked with a local pharmacist to put in place safe systems. The pharmacist had visited on 6 May 2016 and the manager was working through the actions identified. This included the change of position of some medicine storage and resetting the fridge thermometer after each reading was taken. The pharmacist had also recommended

that the manger contact people's GP's to gain their consent to use homely remedies. The manager had acted upon this and letters had been sent and responses received.

Where people had medicines prescribed as needed, (known as PRN), protocols were being put into place about when and how they should be used. The local pharmacist had discussed this with the manager and supplied some suitable documents. New prescribed topical cream charts had been put in place for staff to record when they had administered creams. A senior care worker said as part of their role they checked the charts to ensure people's creams had been administered as prescribed.

It was clear when speaking with senior care workers who undertook medicine administration they were clear about the changes which had been made. They were also following the manager's instructions. For example, hand written entries had been signed by two staff members. One senior care worker said in relation to the changes, "We are trying to change to get better." The manager was also arranging for staff to undertake medicine training updates on the internet.

All medicines were administered by care workers who had received training and had their competencies checked. They had a good understanding of the medicines they were giving out. Care workers were seen administering medicines in a safe way. The provider said in their PIR, "Staff when delivering medicines are to use tabards stating "do not disturb" to eliminate the wrong tablet being given by being interrupted." During the inspection we observed staff were wearing red tabards advising people not to disturb them.

Care workers administering medicines were very patient and did not rush people. They went down to people's level if they were sitting and engaged with them with good eye contact. and offered them water and waited until the medicines had been taken. People said they were given their medication and creams were applied as necessary and they were happy with their treatment. One person said, "I get my medicines every morning roughly the same time."

There was a system in place to monitor the receipt and disposal of people's medicines. Medicines which required refrigeration were stored at the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the care workers and action had been taken to ensure people had received their medicines. Monthly audits of medicines were completed by the manager and records showed actions were taken to address issues identified.

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken and any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. One new care worker said, "I couldn't start until I had that police check (DBS)."

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff had time to meet people's individual needs. People and staff said they felt there were adequate staff levels to meet their needs. One care worker said, "We have enough, if we have someone sick we call others. We have agency if staff can't cover." Another said, "It can be difficult when someone is off sick but perfect when we are all in. (The manager) will always help. The staffing levels are good." People were asked if staff responded to their call bells promptly. Comments included, "Very

quickly" and "Sometimes quite good other times you stay waiting a bit."

The provider said in their PIR, "We ensure we have sufficient staff on duty by using the "Residential Forum Model" to calculate staff hours in relation to resident dependency. Having the right level of skilled staff on duty at any one time. Minimising the use of agency staff where ever possible to provide consistent care." The staff schedule showed during the day there was a senior care worker supported by three care workers, a cook and housekeeping staff and a part time activity person. At night there were two care workers on duty. Staff undertook additional duties with the manager undertaking shifts when necessary to cover gaps. The manager said they were looking to recruit a new part time cook, a cleaner and a night care worker. If required the provider used the services of local care agencies to cover gaps. Staff said they had been given formal written permission to contact designated agencies if they had a shift which they could not cover. They were really pleased to have had this instruction.

Since starting at the service the manager had made changes to the shift pattern at the home. Care workers started their day duty at seven am instead of eight am. The provider had recorded in their PIR, "The service has very recently changed its shift pattern to commence at seven am instead of eight am. This was introduced to provide a larger number of staff to be deployed at the busy time of day when residents need assistance when getting up. This also aids the dispensing of medication as the medication is not being given on top of mealtimes." At a staff meeting in April 2016 staff were asked how they felt the new shift pattern was working. All of the staff present said it worked better and therefore the new shift pattern would continue. One person said, "They start at seven now and usually come just after to get me up. I have been used to getting up early so it suits me."

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service. These were stored in the fire folder and accessible in the event of a fire. There were two styles of PEEPs being used. The manager made us aware that they had spoken with the local fire officer to ask their opinion which they felt most appropriate. They confirmed they were in the process of redoing all of the PEEP's using the recommended document. First aid boxes around the home were well stocked. Staff had completed residents' transfer to hospital documents. These contained people's information so staff could send them with people if taken to hospital. For example, medicines they were taking, medical history and next of kin.

The senior care workers we spoke with were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. They were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the provider and manager about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary. One senior care worker said, "I have never seen anything like that happen here." However only half of the staff at the service had completed training in safeguarding of vulnerable adults. The manager said and their action plan confirmed they had recognised staff training had not been completed by all staff. The action plan stated they would prioritise making sure all staff training was up to date. The provider had placed a notice advising staff regarding alerting abuse on the staff notice board. The notice advised them to contact the providers if they had a concern or the local safeguarding team.

A designated maintenance person worked four days a week at the service. They over saw the maintenance and garden at the service. Staff were able to record repairs and faulty equipment in a maintenance book. Each morning the maintenance person would look at the book and undertake any tasks identified. Staff could contact the maintenance person when not at the service. They also had the contacts of other

emergency contacts in the event of break downs. This included, in the event of a boiler break down. External contractors undertook regular servicing and testing of moving and handling equipment, gas, portable appliance testing (PAT) and stair lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. The manager had carried out a fire drill the week of our visit. They said they would continue having drills to ensure all staff were clear about the fire procedures. Throughout the building there were keypads in place on external doors. The fire service had visited in 2014 and said they were satisfied with the fire arrangements within the building.

The home was clean throughout without any odours present and had a pleasant homely atmosphere. With the exception of one toilet which was odorous on both days of our visit although appeared clean on. We discussed this with the provider who said they would look at the cause. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. The laundry was small and quite untidy. However soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Requires Improvement

Is the service effective?

Our findings

Staff were skilled and were able to tell us how they cared for each individual to ensure they received effective care and support. They demonstrated through their conversations with people and their discussions with us that they knew the people they cared for well. People said staff listened to them.

Not all staff had completed the provider's mandatory training. The manager had identified that there were gaps in some staffs' training. They had completed an action plan of the areas where they needed to take action and training had been identified. The provider used the services of an external trainer who came to the home to deliver training. Staff were positive about the training they had received. One care worker commented, "The training is really good, and (trainer) is very thorough. The medication training was really good." However if staff did not attend the training organised they had to wait until the next training scheduled. The manager was looking at other training staff could access to ensure all staff had received the providers mandatory training. They had also signed some staff onto courses for a qualification in health and social care.

Staff received regular supervision with the manager, they said they were listened to and could discuss training needs. The manager had scheduled staff appraisals. Staff said they felt supported by the manager. Care workers comments included, "Supervision every three months. It is good we can explore what is best for the home and work as a team. We discuss what we can change for the residents and carers"; "It is good to update what we do, although we can talk to her (manager) at any time" and "I think they are good."

Staff had undergone a basic induction which had given them the skills to carry out their roles and responsibilities effectively. They had completed a checklist with a designated mentor and shadowed experienced senior care workers who taught them the role. One care worker said, "I did shadowing with (senior care worker) for seven days. I have a checklist to complete. I did feel able to look after people when I had finished." The manager said they had not started using the new Care Certificate which had been introduced in April 2015 as national training in best practice. They said they would be looking into using it for the next new and inexperienced care worker that started at the service.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's liberty was restricted as little as possible for their safety and well-being. These safeguards exist to provide a proper legal process and suitable protection in those

circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. There were restrictions to people at the home. This was because the front door to the service had a keypad which required a code to be put in to leave the home. People and visitors did not have access to this code and required staff input the code so people could leave. The manager made us aware at the start of the inspection that they had been in contact with the local authority DoLS team for advice. They said they were in the process of submitting applications for people they had assessed as being deprived of their liberties. They also made us aware that they had recognised staff were not assessing people's capacity if they needed to make a best interest decision. They showed us mental capacity assessment documents which they were putting in place. This is a document staff complete to provide proof that an individual lacked capacity before a decision was made regarding them. For example, consenting to receiving care and treatment at the home. Records showed that staff had undertaken training in MCA 2005.

Care workers were asked about their understanding of the MCA. Their comments included, "I try different ways, I will try three times. If I still can't persuade them, I will ask another carer if they can try. Then if they still don't want to do it they don't have to "and "If people haven't got capacity it helps us know which decisions we can make regarding clothes, food. So we know what is allowed to be decided."

It was difficult to ascertain what legal responsibilities had been appointed to relatives by the court of protection. Staff recorded if relatives said they held a power of attorney. However they had not checked which power of attorney they had. For example whether health and welfare or finance or both. The manager said she would ask people's families to demonstrate the powers they had been appointed.

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the visiting optician, and chiropodist. However people had not had access to a dentist. We identified that one person was resistant to having oral care. They had been at the service a number of years without a dentist visit. On the second day of our visit the manager had contacted the local dental surgery and arrangements were being made for a dentist to visit the home.

Records showed when health concerns were identified and people were visited by health care professionals. Staff took action and followed their advice. However in one person's records we identified they had lost a significant amount of weight in the last month. Staff had recorded this but had taken no action to make health professionals aware. We discussed this with the manager; they said the person had been unwell with an infection. They had just completed a course of antibiotics prescribed by the GP; they confirmed a visit from the GP had been requested. On the second day of our visit the GP had been consulted and they had prescribed a diet supplement.

People confirmed they had been seen by health professionals. Comments included, "They got a doctor for me quickly when I needed one"; "I fell out of bed, they called the doctor and I was sent for an x-ray" and "The optician came in yesterday they were ever so good. The chiropody man comes… he is ever so good as well." Records showed staff had contacted a person's GP because of concerns regarding their pain management. Another person had a district nurse called in because of the risk of pressure damage. The district nurse had recommended a pressure relieving cushion which had been put into place.

People were supported to eat and drink enough and maintain a balanced diet. Everyone was very complimentary about the meals at the home. Their comments included, "The food is nice, I get enough"; "The food is excellent" and "The food is wonderful."

There was a four week menu with a choice of two main meal options and one dessert. The cook said people could have a yogurt or ice-cream if they did not like the dessert on offer. They also said they had consulted

with people and were in the middle replacing the menu with a new summer menu. It was evident that people had made choices by the different meals they were eating.

During the lunchtime period there was a happy atmosphere in the dining room with people chatting sociably. Tables were laid up with place mats and salt and pepper was available where appropriate. The cook served up the meals in the dining room. They chatted with people and served each table is in turn making sure people had the quantity they wanted. Staff were attentive to people's needs and went around offering a choice of drinks and support.

Three people had chosen to have their lunch in their room. A care worker said they had their meal served 15 minutes before the dining room. We visited people in their rooms and they said they had enjoyed their meals.

People who required a special diet were catered for. The cook had clear guidance about people's needs and who required a special diet. They could differentiate between Speech and language (SALT) recommended consistencies of puree and fork mashable consistencies. Speech and language therapists provide treatment and support for people who have difficulties with communication, or with eating, drinking and swallowing. This meant people who required a specialist diet recommended by SALT had the appropriate meal consistency to meet their needs safely.

Good

Is the service caring?

Our findings

Staff were kind and friendly towards people and were seen positively interacting with them, chatting, laughing and joking. A visitor's comment included, "I absolutely could not be more praiseworthy about the care here. I am always fully informed." A person said when asked about the care they received, "Very good, very good." Another said, "The staff are very good."

Care workers said they felt the care people received at the service was good. Comments included, "Staff here are caring. They will always ask residents what they would like… the residents are very friendly. Everyone is really nice and do their job well"; "This is more like a family. It is like I have got a lot of grandparents" and "All of the staff are happy… we have our special residents. We work well as a team, we all care."

Staff talked with us about individuals in the home in a compassionate and caring way. They said they spent time getting to know the person and demonstrated a good knowledge of people's needs likes and dislikes. Care plans were focused on the person and their individual choices and preferences and contained personal histories. This enabled staff to have a good knowledge of people's past and people and events special to them.

Staff were considerate and caring in their manner with people and knew people's needs well. They were friendly and supportive when assisting people. They treated them with dignity and respect when helping with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, covered people and gained consent before providing care. We observed a care worker support a person whose clothes had become undone. They discreetly took them to a bathroom to rearrange the person's clothes to ensure their dignity. One care worker said, "I make sure if we are in the bedroom, I close the curtains. If someone doesn't like to be washed or exposed when undressed, I give them a towel to wrap around themselves. One lady doesn't like a male worker, so we make sure a girl does them."

People's consent for day to day care and treatment was sought. Staff gained people's consent before they assisted people to move and they explained what they were doing and involved the person. They listened to people's opinions and acted upon them. For example, where they wanted to spend their time and if they required further refreshments.

Staff involved people in their care and supported them to make daily choices. For example, We overheard staff giving people choices while delivering personal care in a bathroom and a bedroom. One care worker explained what they were doing, offered the person a towel and asked if they wanted to have a shave. Another care worker was heard asking a person which colour cardigan they wanted to wear.

There had been a significant redecoration at the home which people had been involved in choosing. The provider said it had taken a long time to get a consensus from all of the people able to be included in the decision making. People and the provider said they were pleased with the outcome especially in the summer room.

People's relatives and friends were able to visit when they liked. People and a relative said they were made to feel welcome when they visited the home. One person said, "My visitors are made to feel welcome, they all get a cup of tea." Another explained about a time when their daughter had visited. "The staff were very good; she was made very welcome. They invited them to have a cup of tea." People were asked when they came to the service if they had any preferences regarding who they wanted and didn't want to visit them at the home.

People's rooms were personalised with photographs, items of furniture, teddy bears on beds and ornaments. However some people's rooms were quite bare. Care workers said this was people's choices. On people's doors there were their photographs to help familiarise them to their room.

Requires Improvement

Is the service responsive?

Our findings

People said staff were responsive to their needs. One person said ''I only have to ask and staff will get it for me.'' Another person said ''The staff are very kind and helpful. Nothing is too much trouble."

Before people came into the service the manager would undertake a pre-admission assessment and dependency assessment to ensure the service could meet their needs. A care plan was developed when people arrived at the service. Care plans were written to reflect people's routines during the day and reflected how the person wanted to receive their care. For example for one person's care plan stated, "What morning staff do… likes to sit alone so has an allocated table at mealtimes to facilitate this." Resident assessment forms were completed regarding people's mental and emotional wellbeing, skin and physical appearance. People had been asked to sign their agreement to their care plan. One person had declined because they did not recognise themselves as having continence need.

However people's care plans did not reflect people's changing care needs. They gave staff details about people's preferred routines. However they did not reflect what care and support people required when they become unwell. For example, one person had been unwell and had required antibiotics. They had also lost weight. Their care plan had not been reviewed to reflect these changes. Therefore staff were not guided how to consistently meet this person's changing needs. We discussed this with the manager. On the second day of our visit the manager had put in place a completely new format in people's care folders. These included risk assessments and care plans specific to people's needs. The care plans in place included, maintaining a safe environment, communication, mobility, personal care, health and safety, skin integrity, diet and fluids, continence, religion, social need, sexuality, night time, behavioural matters, medication, capacity and decision making and end of life. The manager and a designated senior care worker were in the process of completing their third person's care file on the second day of our visit. The provider said they would implement the new system in everyone's care folder within two months.

Care plans had been reviewed every six months. The manager had recognised this was not regular enough and had put in place monthly reviews. These had been completed in March and April 2016. The manager said they were supporting staff to build up their confidence with writing people's records. They said they had implemented a monthly care plan review and changes would be added as they occurred.

Staff had made the decision to put in place food and drink monitoring charts for the person who had lost weight. However staff had not been guided regarding how much fluids the person required. There was no system to collate the amount of fluids the person had received. On two days during the week we visited they had received less than 500 millilitres. We discussed this with the manager who said they were sure the person was receiving more fluids that what had been recorded. On the second day of our visit the manager had put in place new food and drink monitoring forms. Staff said they were discussing people's dietary and fluid intake at shift handovers. One senior care worker said they had discussed the new forms with the manager and were going to be collating the information to ensure people had the required amount of fluids.

Activities formed an important part of people's lives. A designated activity person worked at the service for

18 hours a week. A programme of planned activities were on display on the notice board in the main entrance to make people aware of the activities on offer. These included on a Wednesday afternoon a chat and games and three mornings a week, exercises, singing, back massage, mystery tour which includes walks picnics, visiting the tea room in museum. The cook also worked additional hours in the afternoons to undertake activities with people.

Staff recorded the activities people took part in using a tick sheet with a code system. For example, a tick if they had played bingo, been reading, played board games, listened to music, or taken part in a quiz. Additional things had been added like 'had a chat and one to one'. These records showed one person in the month of April had joined in a singalong, worked on a jigsaw, dance, arts and crafts, physical activity and exercise. Another had joined in most of these activities and also watered the garden. People were very complimentary about the activity person. One person commented, "I can go out in the garden when the weather is good. (Activity person) is very good she brought me a book yesterday with pictures going back years. It is brilliant."

Records of the residents meeting in February 2016 recorded that "All residents are happy with their activities." It also stated that a lot of activities were brought into the home such as donkeys, guitarists, singers and pantomimes. A visitor said, "A lovely friendly atmosphere here. They sing and dance, it is wonderful."

The provider had a complaints procedure which made people aware of how they could make a complaint. The complaints procedure referred to the Care Quality Commission (CQC) dealing with complaints which is inaccurate as CQC do not deal with complaints. It also did not identify any other outside agencies people could contact which included the local government ombudsman. We discussed this with the registered provider and the actual role of CQC. We also identified in one room there was an old complaints procedure which referred to the predecessor to CQC. The provider said they would rewrite the complaints procedure with the correct information and put a new one in each room. The provider recorded in their PIR, "Most complaints are dealt with informally with the manager but the service has a formal complaints policy."

People said they would feel happy to raise a concern and knew how to. Comments included, "No complaints, very good not changed much."
The manager had received two complaints in the last twelve months. They had responded to the complainant in line with the provider's policy. The provider recorded in their PIR that the main complaints they received were about people's laundry. They recorded, "Some residents' clothes get mixed up as they are very similar in colour, size and type. Having tried in the past with washable labels that fall off after little use the service has researched a product (Snappy Tags). These have the residents name on in a clear manner and is very easy to apply to the clothes as well as being more durable." People said they had heard about the new tags being trialled and hoped they would make a difference. One person commented, "Sometimes I get others and mine goes missing. They are trialling new tags."

Requires Improvement

Is the service well-led?

Our findings

Staff spoke positively about the manager and said they had made significant changes and improvements at the home. The manager was in day to day control at the service and said "We have a good core of staff." They were supported by senior care workers and worked alongside staff.

Staff comments about the manager included, "(The manager) is a great help. We have great owners but it is better to have a person to share our problems. She has great ideas. It is much better, I love this home, I can see the difference from when I started here"; "(Manager) is on the ball"; "It is nice as (manager) is here helping. She will help on the floor. We can ask her anything and she will help" and "Loads of changes… new paperwork. She will ask, do we agree with what we are doing. All of the changes are for the better, for staff and residents."

People were also positive about the new manager and providers. Comments included, "Lovely place…the people who run the unit are lovely."

The manager was supported by the registered person who worked at the home on a daily basis. The manager said they were supportive and backed the changes they were making. The manager said the registered manager of the providers other home was also available at the end of the phone to support her. The manager said they were planning to meet up to get ideas and discuss issues. The provider said they had scheduled supervision with the manager to discuss where they saw the service and what they felt needed to be done.

People's views and suggestions were taken into account to improve the service. The manager recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided. They held a well-attended meeting in February 2016 where family, friends and relatives were also invited. They had asked people how frequently they wanted to have a residents meeting. One person had requested them every two months and another person wanted them twice a year. The manager said she would look at ways of meeting all people's requests. Other topics discussed included staff wearing name badges, new laundry tags being trialled and making gender specific toilets for men and women which the manager would look into arranging. The manager also reminded people that although her office was not in the main part of the home that she was always available if they asked a staff member they would come down. People were positive about the residents meeting. One person said, "If we have one you can have your say, I have no complaints about food or room so nothing to worry about."

People had been asked to complete a questionnaire about the service. The surveys asked questions about the staff, laundry services, meals, activities, environment and personal care. The manager was in the process of getting back the responses. Comments seen were on the whole positive. The manager said they would be collating the results and sharing them with staff and people. This would be at a residents meeting and they would place a report on the notice board.

A survey of relatives and visitors in the summer 2015 highlighted people's concern about the amount of car

parking at the home and the condition of the drive. As a result holes had been filled and staff were parking at an alternate location so there were more parking spaces.

Staff were consulted and involved in decisions making about the service through regular staff meeting held four times a year. Staff said they felt informed and listened to. The last meeting held in April 2016, seven staff attended along with the manager. The manager discussed the improvement in how the staff were working as a team. Other topics discussed included, improvements of the laundry door being kept closed, confidentiality and staffing levels. On the staff notice board the dates for the four meetings in 2016 were on display. Along with an agenda for the next meeting which staff could add to. One care worker commented about the last staff meeting, "We had a staff meeting it was quite positive…nice to hear about how we are doing and what needs to get better."

A range of quality monitoring systems were in use which were used to continually review and improve the service. The manager had implemented an action plan identifying the areas they had identified which required improvement. An example recorded in the action plan included, monthly medicine audits. They had started undertaking these audits. Following the medicine audit in April 2016 they had put the actions identified on the staff notice board to advise staff. These included always having two staff to sign to say when a change has taken place. When we looked at people's medicine records all changes had been signed by two staff.

The provider had a range of audits which had been completed in 2015 and were going to be undertaken by the manager once they had settled in post. The provider had completed a room audit in February 2016. Everything they had identified as a high risk to people had been addressed. Annual fie risk assessments were also completed by the provider. The last one was completed in March 2016.

The manager was working with the house keeper to put in place a cleaning schedule. The housekeeper said "They had a record of rooms and what they had completed." They showed us the records and it demonstrated that they had pulled all of the furniture out, hoovered and wiped down the paintwork
There was an on call system at the service. The designated person either the manager or senior care workers were recorded on the staff schedule. This meant staff had someone they could contact if they needed guidance or support.
The service worked with other health and social care professionals in line with people's specific needs. People and staff commented that communication between them and the other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP's, speech and language therapist, district nurses, community psychiatric nurse and physiotherapists.

Staff had access to a range of policies and procedures to guide their practice. The manager and provider were in the process of reviewing these and updating as necessary.

In August 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored five with the highest rating being five. This confirmed good standards and record keeping in relation to food hygiene had been maintained. Where they had made one recommendation about the side of a work surface which needed to be replaced; this had been actioned by the provider.

There were accident and incident reporting systems in place at the service and a 48 hour monitoring log. The manager reviewed all of the incident forms regarding people falling. They looked to see if there were any patterns in regards to location or themes. Where they identified any concerns or reoccurrence they took action to find ways so further falls could be avoided.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as when a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested and working in line with their registration.