Hartford Care Limited

Stokeleigh

Inspection report

19 Stoke Hill
Stoke Bishop
Bristol
BS9 1JN

Tel: 01179684685
Website: www.hartfordcare.co.uk

Date of inspection visit:
19 April 2016

Date of publication:
31 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Stokeleigh on 19 April 2016. When the service was last inspected in April 2015 there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified. We found procedures for preventing the risk of cross infection were not always followed. People had not always been protected from the risks associated with medication. People's rights had not always been fully protected in line with the Mental Capacity Act 2005 and people's healthcare needs were not always effectively met. These breaches were followed up as part of our inspection.

Stokeleigh provides accommodation and personal care for up to 30 older people, some of whom are living with dementia. At the time of our inspection there were 28 people living at the home.

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

People said they felt safe living at Stokeleigh. Medicines were managed and administered safely following the home's procedures and individual protocols. The action taken by the home following the last inspection in April 2015 ensured that improvements had been made. Safe recruitment procedures were in place and new staff completed a full induction aligned with the Care Certificate. Staff received regular training to ensure they were skilled and effective in their roles. We did highlight that specific training relating to particular needs of people, for example those living with diabetes would be beneficial.

Staffing levels were sufficient to be safe. However, staffing levels did impact on the amount of support available to people during mealtimes, for personal care and in accessing the community.

Staff understood the principles of the Mental Capacity Act 2005 and applied these in their role. Best interest decisions, when needed, were made in accordance with guidelines and with involvement from families and health and social care professionals. Applications were made when appropriate in relation to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care or need protecting from harm. However, we found that the conditions set out in people's DoLS authorisations were not always being met.

People's healthcare needs in relation to hydration and nutrition which had not previously been met were now identified and monitored. Information was recorded and areas of concern communicated to staff. When needed, further involvement from healthcare professionals was sought.

The feedback from people was positive about the care they received and the staff at the home. We observed staff being kind, attentive and treating people with dignity and respect. People's visitors were welcomed at

the home. However, people could not always enter the home in a timely manner.

The home provided a range of activities and we observed people participating and enjoying themselves. However, some feedback suggested people lacked stimulation and people said they wished to go out more.

Care plans were personalised. They were well organised and accessible to people. Feedback was sought from people, relatives and staff through meetings and questionnaires.

People and staff told us the home was well-led and managed. The home had systems in place to monitor the quality of care.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of 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?

Good

The service was safe.

People's medicines were managed safely.

Staffing levels were sufficient to ensure people's safety. Safe recruitment procedures were followed.

Staff knew how to recognise potential signs of abuse and how to report safeguarding concerns.

Risk assessments were in place for people, the premises and environment.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not meeting the Deprivation of Liberty Safeguards as people's conditions as part of their authorisations were not always being met.

Best interest decisions were made in accordance with the Mental Capacity Act (MCA) 2005. Staff had a good understanding of the MCA.

Staff had effective induction and training.

Risks were effectively managed in relation to hydration and nutrition.

Is the service caring?

Good

The service was caring.

Staff were aware of people's preferences and knew people well.

Staff were attentive and kind.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People took part in activities arranged by the home. People had limited access to the community.

Feedback was sought from people and relatives but was not always promptly acted upon.

People's visitors were welcomed at the home. However, they could not always enter the home in a timely manner.

The home had a complaints system in place. Effective improvements were not always made.

Care records were clear, accessible and person centred.

Is the service well-led?

Good

The service was well-led.

People spoke positively about the registered manager.

Staff felt supported and valued by the registered manager.

There were systems to monitor the quality of care provided.

Stokeleigh

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.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and the information we had about the service including statutory notifications. Notifications are information about specific important events that the service is legally required to send us.

Some people at the home were living with dementia. This meant they were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

During the inspection we spoke with 16 people living at the home and two relatives. We spoke with the registered manager and five staff members which included the deputy manager, activities co-ordinator and the chef. After the inspection we spoke with a further two members of staff. We gained feedback from two health and social care professionals.

We looked at five people's care and support records and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Good

Is the service safe?

Our findings

At the inspection of Stokeleigh in April 2015, we found the provider had not ensured procedures were followed to fully protect people against the risks of cross infection. In addition to this, the provider had not ensured people were fully protected against the risks associated with medicines. In May 2015, the provider sent us an action plan setting out how they would achieve compliance with the regulations. During this inspection in April 2016, we found the provider had taken the action they had planned in order to meet the regulation.

The ordering, retention, administration and disposal of people's medicines were safe. Medicines were signed into the home following a weekly delivery and recorded on people's Medicine Administration Records (MAR). Medicines were stored within a locked medicines room. Medicines that required storage in accordance with legal requirements had been identified and stored appropriately. Registers of these medicines matched the stock numbers held. The temperatures of the medicines room and the medicines refrigerator were recorded daily to ensure medicines were stored correctly.

We reviewed a sample of people's MAR and no recording omissions from staff were identified. We saw that the recording of variable dosage PRN [as required] medicines such as paracetamol showed the quantity of the medicine administered. Within people's care records there was a PRN protocol for people who received this type of medicine. This showed the medicine, the dosage, the maximum dosage in a 24 hour period, the reason for administration and possible side effects. In addition to this, there was guidance on when staff should contact the person's GP, for example when it was evident the PRN medicine was not effective and the person's symptoms persisted.

We observed medicines being given to people during our inspection. We observed staff were patient with people, waiting for them to take their medicines before completing the MAR to show that people had received their medicines. Staff received training in medicine administration and the registered manager completed six monthly competency assessments. There were systems to audit the storage and recording of medicines. The pharmacy who supplied the medicines completed a six monthly inspection. It was noted the staff signature sample sheet required updating as some staff who were no longer employed were still listed.

People told us they felt safe living at Stokeleigh. People told us they were happy with how their medicines were given and felt safe moving around the home. One person said, "I feel safe and settled. If not I will tell whichever carer is on the job. They will listen and do something about it." People told us staff were attentive but very busy. One person said, "Staff are there when you need them but are always rushing." People said they worried about falling over and appreciated measures to ensure they felt reassured and safe. For example, "Not waiting long for someone to come if I call."

Staff understood their responsibilities in relation to safeguarding adults. The provider had safeguarding and whistleblowing policies for staff. This included guidance and information on the different types of abuse people could be at risk of in a care home environment and what action should be undertaken by staff

should they be concerned for a person's welfare. Staff we spoke with were knowledgeable about safeguarding reporting procedures. One member of staff said, "I would report any concerns to the manager or deputy." Staff told us they understood the concept of whistleblowing and how they could contact external agencies in confidence if they had any concerns.

We viewed the staff rotas from the previous eight weeks and the number of staff on duty was consistent with the planned staffing levels. One person said, "There are enough staff. I get what I need." The home was currently recruiting for two day and two night members of staff. These vacancies were being covered by existing and agency staff at the present time. The home had undergone changes within the staff team, with a significant amount of new staff joining in the previous year.

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. References had been obtained by the home together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. The provider had also completed additional DBS checks for staff who had been employed at the service for a long period of time.

Reported incidents and accidents were reviewed to establish any patterns or trends. The registered manager had a system to record, monitor and review incident or accident reports. This review was completed with the aim of preventing or reducing the risk of the incident or accident from happening again. Staff we spoke with were knowledgeable about what they were to do in the event of an incident or accident. Each person had their own individual record for incident s and accidents that had a supporting accident form giving the details of the incident if required. This record also showed if the person's GP was informed and if the GP attended. A further overall audit was completed that showed a running total of incidents and accidents and any subsequent actions taken.

The environment and equipment was maintained to ensure it was safe. The provider had dedicated maintenance staff that monitored all aspects of the environment and the equipment within the home. Environmental risk assessments were completed to reduce any evident risks. Additional records showed that regular maintenance and servicing of mobility equipment was undertaken. For example, regular audits of the serviceability of bed rails in use were completed and mobility equipment such as wheelchairs, hoists and slings were also subject to regular checks and servicing.

Fire alarm checks were completed and the emergency lighting and firefighting equipment was monitored. People had an individual emergency evacuation plan (PEEP) in their care records. This detailed how people would respond on hearing the alarm and the support people would require to stay safe. The provider also had a business continuity and emergency response plan in place. This gave information and procedures on what to do if there was disruption to the service through a health epidemic or adverse weather conditions. This ensured that people's needs would still be met.

The risks of people being harmed were identified through appropriate assessments and risk management guidance where required. Care records contained risk assessments. This included people's risk of falls, their risk of skin damage and their risk of malnutrition or obesity. An assessment had also been completed and the level of support and staff intervention people required for moving and handling. Where a risk was identified there were plans in place to inform staff how to keep people safe. For example, within one person's record it showed a person living with dementia was at risk of falls as they would at times forget to mobilise with their mobility aid. Guidance showed staff were to complete regular checks of the person and

to provide support and supervision if needed.

The home was clean and there were dedicated domestic staff to ensure the home was cleaned frequently. Staff were observed wearing personal protective equipment such as gloves and aprons at times when personal care was being given. Staff were also observed wearing hats and aprons during meal periods. Liquid soap was available within the toilets and hand washing guidance was wall mounted for people and staff to see. It was noted that some of the bins within the shared toilets throughout the home did not have a lid. This meant tissue paper or paper towels were exposed. To ensure cross infection risks were reduced a pedal operated bin would mean these were contained and people would not have to touch a lid when opening the bin.

Requires Improvement

Is the service effective?

Our findings

At the inspection of Stokeleigh in April 2015, we found that people's rights were not fully upheld in relation to the Mental Capacity Act 2005. This included the process of making decisions in the best interest of some people at the home. In addition, we found that people's healthcare needs were not always met in relation to repositioning, nutrition and hydration.

In May 2015, the provider sent us an action plan setting out how they would achieve compliance with this regulation. During this inspection in April 2016, we found the provider had taken the action they had planned in order to meet the regulation. At the time of our inspection the registered manager told us that nobody required support in relation to repositioning. Therefore, we could not assess if this was now being addressed effectively.

The Mental Capacity Act (MCA) 2005 provides the legal framework to protect people who may lack the mental capacity to make their own decisions about their care and treatment. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be lawfully deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. At the time of our inspection there were three people with a DoLS authorisation living at Stokeleigh and an application had been made to the local authority for a further 15 people.

Within a DoLS authorisation, the person who has granted the authorisation may impose a condition on the service as part of the authorisation. The service is legally obligated to meet the conditions set within the authorisation. Following a review of conditions attached to two people's DoLS authorisations, we found the provider had not initiated or met these conditions. For example, within one person's authorisation dated 29 June 2015 there was a condition. The condition stated the provider must ensure an Independent Mental Capacity Advocate (IMCA) was appointed for the person and that the IMCA should visit the person and subsequently liaise with the person's representative. The registered manager told us this person did not have an IMCA appointed and there were no supporting records to show any attempt to comply with this condition had been made. It was also noted that steps taken within the DoLS process could be documented and recorded so key information was clear. For example, when an authorisation was applied for, due to expire and related conditions. This would mean it would be easier for the home to monitor and check they were compliant with their responsibilities.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had acted in accordance with principles of the Mental Capacity Act (MCA) 2005 in relation to best interest decision meetings. Best interest decision meetings are held when a person lacks the mental capacity at that particular time to make a specific decision about an aspect of their care or treatment. Records showed that meetings had been held in relation to the care a person was receiving at Stokeleigh and if the person could contribute to their care plan. Where a person had bed rails, a mental capacity

assessment had been completed to establish if the person could understand and retain the information being given to them about the use of bed rails. Further records showed that meetings were held between staff and members of people's families in relation to specific decisions such as using a pressure alarm mat in a person's room.

Staff we spoke with understood the principles of the MCA and how they applied these to their role. Staff told us how they assumed people had the capacity to make decisions, respected people's choice and were aware how people made their decisions. Staff told us they always asked for consent before care and support was given. Staff we spoke with said they always knocked before entering a person's room or asked people what clothes they would like to wear and offered choice. We viewed in one person's daily notes that choice had been recorded. 'I showed her two tops and [person's name] decided what she wanted to wear.'

People were able to access healthcare services when required. People were registered with local GP practices. Records indicated that people's GPs were communicated with frequently and any concerns were promptly raised. Additional healthcare provision was given by visiting chiropodists and where required, the local community nursing team. We spoke with a community nurse who was visiting on the day of our inspection and a local GP practice. They told us they had no concerns about the care provided by staff and that staff were efficient and helpful in their company.

The provider had an induction process which encompassed the Care Certificate. The Care Certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the certificate. In addition to the Care Certificate new staff completed an internal induction. This included learning about relevant policies and procedures and knowing key information about the service and the building. All the staff we spoke with confirmed they had shadowed a more experienced member of staff as part of the induction process. New staff were further supported with progressive supervisions through the initial stages of their employment.

Staff received regular training in a variety of subjects so they could care for people effectively. This included both face to face training and e-learning. The records showed staff had completed training in manual handling, dementia awareness and first aid. Staff spoke positively about the training they received. Staff said the knowledge they gained supported them to develop in their role. However, we found that no training for staff had been provided in diabetes. Several people living at the home had diabetes. Staff not having the correct skills and knowledge in this area could lead to unsafe care and support.

Staff received support through regular performance supervision with the registered manager. The registered manager told us that staff should receive supervision approximately every two months and an annual performance appraisal. One staff member said, "Supervision is useful, it is good to have." Staff felt supported by the registered manager and we reviewed the supporting supervision and appraisal records. Supervision records showed that matters such as the staff member's performance and role were discussed, together with their knowledge of their role, the staff member's effectiveness and the quality of their work. Where required, the registered manager had completed reflective supervision where standards had fallen below that required. This supervision included discussing the issue, what had been learnt and what would be done differently in the future to ensure effective care for people was provided. Following a review of the most recent quality management audit, it was highlighted that supervision and appraisal were only 58% completed. The registered manager told us this would be addressed.

There was a system to monitor people's nutritional risks. People had their weights recorded monthly and a record of this was maintained. The service used a nationally recognised assessment tool to establish a

person's risk of malnutrition or obesity. The registered manager told us that no person in the service was currently at risk of malnutrition. Where people had been prescribed liquid nutritional supplements, records showed they had received these as prescribed. The home had arranged a nutritional week, which was shown on the resident's noticeboard. This focused on activities and information around healthy and balanced nutrition.

If people were identified as being at risk in relation to hydration, their fluid intake was monitored and recorded on a fluid chart. People were monitored through fluid charts for an acknowledged period of time. We viewed a sample of fluid charts and found they had been fully completed. Where people's fluid levels had been below a particular stated amount, what had been done to support the person to take on board more fluid had been recorded. This information was handed over to the next shift both verbally and within the handover record to ensure this continued to be monitored.

The feedback we received in relation to meals was mixed. One person said, "Excellent food, possibly too much of it." Another person said, "It is boring and lacks variety." General comments were a wish for more salads, fresh vegetables and fruit. Two complaints we viewed and feedback we received during the inspection commented on the serving of tinned fruit salad on a regular basis as opposed to fresh fruit. This was highlighted to the registered manager who said it would be addressed.

We observed throughout the inspection people being regularly offered a variety of drinks, biscuits and cakes. People did have access to the kitchen and could help themselves if they wished, but tended not to. People told us that they sometimes wished for something to eat during the evening or at night. People said they could ask the night staff and they would provide food and drink. However, people said they would like easier access to make their own drinks and snacks. The registered manager told us of plans to create a well-being kitchen area in the dining room. This would enable people to independently access drinks and snacks whenever they wished.

The chef was knowledgeable about people's dietary requirements and needs based on medical conditions, intolerances and preferences. The registered manager would inform the chef of people's needs and a board displayed in the kitchen showed people's requirements. People with particular needs would be consulted during the morning as to what they wished to have that day if they required an alternative to the two choices available. The chef had gathered feedback some time ago by speaking to people on an individual basis to gain more insight into their preferences and comments about meals. The chef also attended the residents meeting in order to gain feedback.

During our lunchtime observation we saw that people could be sat waiting for some time before the meal was served. As staff also served people meals in their rooms at the same time it meant that the available staff support for people was limited. One member of staff was on their own for 15 minutes supporting 17 people. One member of staff said, "Extra support at mealtimes is needed." Staff were attentive and aware of the support people needed in terms of encouragement, making the food accessible and ensuring people had their needs met. Staff ensured people ate at their own pace and were not rushed.

Good

Is the service caring?

Our findings

People told us the staff at Stokeleigh were kind and caring. One person said, "I like the staff, they are alright. They are kind to me." Another person said, "Staff treat me kindly, they are thoughtful and discreet and take it beyond its limits." One relative said, "They know my loved one so well and are gentle and kind." Another relative said, "Staff are lovely, thoughtful and conscientious."

Some people were able to tell us about the care and support they received. People told us they were treated with dignity and respect. One person said, "The girls are lovely." Another person said, "Staff are caring and there when you need them." People told us their privacy and dignity was maintained during personal care. People said the staff were considerate and always ensured doors were closed and curtains pulled.

Some people were not able to tell us about the care and support they received. We made observations throughout the inspection and during mealtimes. We saw staff interact with people in a kind and compassionate manner. We saw people called by their preferred name and staff using appropriate volume and tone of their voice depending whom they were speaking with. We observed a member of staff helping a person who was having difficulty with their mobile phone. We saw another member of staff reassure a person who was upset and distressed.

During a mealtime we observed staff be attentive, friendly and fun with people. The home had altered how people choose their meals. They found people sometimes could not recall what they had chosen if asked in advance. Meal choices were displayed on a board and staff would bring out the different options and show people what was offered. Those people with particular dietary requirements were previously consulted. This meant it was easier for people to make their choice visually. Staff commented about the positive impact this had, with people finding it easier to make a decision and being happy with their meal choice. We observed staff showing people different options and giving people the time they needed to choose. Staff offered people assistance in a kind and polite way. One member of staff said, "Do you need any help? Can I cut that up for you?" Staff reassured one person who was anxious by saying, "Take your time, you are doing fine." We observed someone who required individual assistance to eat their meal. Staff supported them in a sensitive and unhurried manner.

Care plans gave clear information on people's preferences and personal history. Staff were knowledgeable about how people communicated. We observed staff wait when having asked a person a question and give them the time they needed to respond. Staff listened thoughtfully and acted accordingly. We saw when people were unable to communicate verbally or articulate their thoughts staff responded to non-verbal indicators such as facial expressions and body language. One staff member told us, "Communication is key to a caring relationship with people."

The home had received five compliments since January 2015. One read, "Thank-you, all the staff. We do appreciate it." Another said, "We want to thank-you all for your kindness and support." A relative had written, "I take this opportunity to thank the manager and all her staff for their dedicated service." A

volunteer had written, "Thank-you for allowing me to volunteer in such a friendly environment." Seven positive ratings had been made on a national website where care experiences could be reviewed in the last 12 months.

The provider had produced a hospital transfer form for people. This record ensured that if a person was admitted to hospital, key information would be available for ambulance and hospital staff to help them support the person. This could reduce the person's anxiety or distress whilst being in an unfamiliar environment, in particular if the person was living with dementia. The record contained personal details such as how the person communicated, if they had difficulty hearing or understanding certain things. Additional information such as the person's personal care preferences, their mobility needs and any preferences for eating and drinking were recorded.

Staff showed they knew about confidentiality and what this meant to their role. For example, not sharing people's personal information inappropriately. One member of staff said, "Respecting that information is private. Not sharing information unless appropriate to do so."

Requires Improvement

Is the service responsive?

Our findings

We received feedback that Stokeleigh was not always responsive to people's needs and preferences. People spoke to us about not being able to bathe and shower as much as they would like and not being able to access the community frequently. One person said, "I would like to shower more." Another person said, "I would like to go out."

People and relatives said they would complain if they felt a need to. One person said, "I would not put up with anything and would definitely complain." The home had received four formal complaints since January 2015. The complaints we viewed all contained similar concerns. Laundry and ironing not being completed and returned to the correct person. Personal care not being completed as directed in the care plan and a lack of fresh food. Complaints were investigated and responded to. However, follow up to some complaints to ensure the complainant was satisfied with the outcome had not always been recorded. Also, as similar concerns had been raised by different people a clearer record of the exact action taken and subsequent monitoring to ensure that effective improvements were made would avoid reoccurrence. People could not be confident their complaints would be fully addressed and action taken to improve the service.

The registered manager told us that a new system was in place where a particular member of the night staff team had dedicated responsibilities around people's laundry and ironing. Staff we spoke with this said this arrangement was having a positive impact. One staff member said, "The laundry system with the night staff has helped." However, considering this system had been in place for several months, relatives we spoke with said that laundry was still not being returned to the correct people.

Several people told us they did not have a bath or shower as often as they would like. This was also mentioned in information received by the registered manager in feedback, surveys and in a complaint. People and the registered manager told us they were able to ask for one if they wished. However, people told us that staff could not always accommodate their wishes. We viewed four care records of people that required assistance from staff in maintaining good levels of personal hygiene. In people's daily notes there was a coding system where in the margin staff could write a letter which corresponded to an activity or task. For example, changing the bed or having a bath. There was no code for showering only for bathing. In the records we viewed, the coding system was not consistently used by staff. In addition the notes that were written did not often refer specifically whether a bath or shower had occurred or if one had been offered and declined for any reason. The daily notes made comments such as "washed and dressed" and "personal care given" but were not clear what this consisted of. One person's daily notes did not contain any record of the person having had or being offered a bath or shower from 1 April 2016 – 19 April 2016. The coding system during this timeframe had not been used at all. It stated on several occasions they had washed and dressed themselves despite the care record stating, 'I need the assistance of a staff member to help me maintain a good level of personal hygiene.' Another care record that we viewed stated, 'I have a bath once a week as requested.' The daily notes clearly recorded the person had a bath on 5 occasions from 1 April – 19 April 2016.

A residents survey had been conducted in January 2016. Overall the feedback was positive. The findings and comments were due to be discussed with people at the forthcoming residents meeting later in April 2016. Comments made echoed previous feedback received for example, "Organise washing better" and "I would like a shower every morning."

People and staff told us family and friends could visit the home whenever they wished and there were no restrictions. However, feedback we received highlighted that visitors could not always gain access in a timely manner to the home. One person said, "It is an issue, people have been known to wait 10-15 minutes." If staff were all involved in supporting people at that time, it meant no-one was available to answer the door. This was reiterated by a visiting health professional who commented that delayed access had an adverse effect on their schedule. The registered manager was aware this needed addressing..

A residents meeting was arranged four times a year. We viewed the minutes from the last residents meeting in January 2016. The minutes showed people were fully involved. People gave their feedback around the food and menus, activities and anything else they wished to discuss. People made positive suggestions of food or activities they would like to try. Items such as safeguarding and fire safety were discussed to ensure people understood what to do in these events. People that did not wish to attend the meeting were spoken to on an individual basis so they had a chance to contribute their views and opinions.

The home facilitated a meeting for people's relatives' four times a year. We viewed the minutes from a meeting held in September 2015. The meeting was an open forum for relatives to discuss anything they wished. The minutes from the most recent meeting held in January 2016 had not been typed. This meant that families had not yet received copies of the minutes or any details of actions taken from the meeting.

A co-ordinator arranged activities five days a week. There was a plan of activities for the week which was displayed. We saw that bingo, sing along, manicures, scrabble and cards were offered. A tea party had been arranged for St Georges day and talks from community representatives had also been arranged. Outside entertainment such as music groups visited on a regular basis. A weekly church group was also on offer. The co-ordinator also gave one to one time to people who remained in their rooms. We observed people participate and enjoy the activities on offer. Comments made in the recent residents meeting in relation to activities were generally positive. One staff member said, "There is enough for people to do." The registered manager and staff told us that when the weather was warmer people would go on walks in the local community. Staff told us they supported people to access the gardens, which were large and well maintained.

Despite the variety of activities on offer we received feedback from people, relatives and a health and social care professional that people lacked stimulation. One person said, "I am bored. The activities co-ordinator does their best and the activities are as good as can be." Several people told us they wished to go out more. One person said, "I want to go out." Relatives commented that people would benefit from more time with staff, especially those who spent time within their rooms. One relative said, "The staff are marvellous. They know my relative and understand them. I only wish they could spend more time with them." There was no plan in place for outings, walks or trips on a regular basis. During the inspection we did observe staff sit, chat and spend time with people when they were able to.

Care records were clear, accessible and contained personalised information. For example, people life histories had been recorded. This gave staff information on where people were born, their education, what people did for employment and any significant life achievements. This information can aid staff in communicating with people, particularly those living with dementia as it may trigger memories or familiarity. Personalised information about the level of support people preferred was recorded. This

showed the person's individual needs in relation to daily tasks such as drying after a shower, washing their hair or brushing their teeth. Care records had clear guidance and used pictures to make them accessible. This showed the service tried to promote people living as independent a life as possible.

Where required, people had a dementia care plan responsive to their individual needs. The record showed the type of dementia the person was living with, what level of care the person received to support them with their dementia and their current medication. In addition to this, it showed how the person was affected by their dementia. For example, within one person's record it showed how they frequently became confused and believed they were in a different location and not at the home. This level of information gave staff important information to enable them to support people in a person centred way.

There were systems to ensure that care records and people's risk assessments were regularly reviewed. Where possible, people had been involved in their reviews and were actively involved in their care. We saw that a monthly review of people's mobility and fitness, activities, personal hygiene, oral health and medication was completed. Where records and assessments had been identified as requiring updating or altering this had been completed. However, we found that a person's care plan who had recently been admitted to the home lacked detail in regards to a medical condition. The pre admission assessment contained information in regards to this but there was no guidance or information to staff in the care record. This meant that staff would not be able to be fully responsive to this person's condition and needs.

Good

Is the service well-led?

Our findings

People and staff spoke positively about the management of the home. We were told that the registered manager was visible and approachable." One person said, "I would speak to her if I was worried." Another person said, "The manager will stop and chat."

Staff described the registered manager as helpful and open. One staff member said, "The manager is good. You can raise issues." Another staff member said, "The manager has been very supportive to me." Relatives told us they had a good relationship with the registered manager.

The atmosphere of the home was described by one person as, "Happy and friendly." A member of staff said, "It is welcoming and friendly here." Another staff member said, "It is a nice place to work." Staff said they felt valued and worked well as a team. One staff member said, "It's a good staff team, we get on well." Another member of staff said, "The carers work well together as a team."

Information was communicated to staff through handover information, a diary and a notification folder of significant information. Daily notes were kept for each person so information was communicated to the next shift. One staff member commented, "We communicate well and the staff report any concerns."

The registered manager arranged regular team meetings. We viewed the minutes from September 2015 and January 2016. Staff meetings were used to improve knowledge and skills. We saw the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were discussed to embed staff members' understanding and give people an opportunity to raise any questions. The policy on whistleblowing was discussed. Topics such as forthcoming training, staffing and domestic arrangements were noted. Staff were able to make suggestions. They had highlighted a need for another carer at a particular time and this was now in place. However, actions that may have arisen from the meeting were not recorded. There was a sheet attached to the September minutes for staff to sign to show they had read the minutes. Only a few staff had signed this. The January minutes were not typed and therefore had not been distributed for staff to view. This meant staff were not receiving this information in a timely manner and items discussed may then not get actioned.

Staff had completed a survey in November 2015. The results were analysed and published. Overall they were positive. Relatives told us they had completed satisfaction cards asking for feedback but were unaware of the findings.

Regular audits took place to check and monitor the quality of the service. Internal audits checked areas such as infection control, medicines and staffing. For example, these looked at people's bedrooms, staff hand hygiene, staff supervisions and absence. Quarterly audits also took place of care plans. Provider audits were also completed on a regular basis. These monitored accident and incident records, the premises and environment. A regional manager had conducted an audit in January 2015 which focused on the business element of the home. It was brought to the attention of the registered manager that when areas had identified the need for action, these be signed on completion. This ensures it is clear what has been done and when.

The registered manager attended external forums and meetings with other care managers. This supported the registered manager to keep up to date with current best practice and gave opportunities for development and learning. The registered manager had achieved nationally recognised qualifications in care and also attended relevant training such as management training.

The registered manager understood the legal obligations to submitting notifications to the Commission and under what circumstances these were necessary. A notification is information about important events which effect people or the home. The registered manager had completed and returned the PIR within the timeframe allocated.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had disregarded the needs of some service users by failing to meet the conditions set out within Deprivation of Liberty Authorisations.