Ridgemede Care Limited

Ridgemede Care

Inspection report

Bishops Waltham
Southampton
Hampshire
SO32 1DX
Tel: 01489 892511

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Ratings

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

Overall summary

We conducted this unannounced inspection on 4 and 5 August 2015 in response to concerns received about people's safety.

Ridgemede Care provides accommodation and personal care for up to 36 older people who were frail and some were living with dementia. Accommodation is provided over two floors in a converted domestic dwelling. At the time of our inspection 31 people were living in the service.

The service has a registered manager and she has managed the service since 2001. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had introduced some systems to monitor the safety and quality of the service provided over the past year. However, we found improvements were needed to ensure these systems were effective in identifying issues of quality and safety so that robust action would be taken to manage risks in the service. Overall we found that the service was not always well led

Summary of findings

and that management systems were not always fully in place or robust. Some records relating to the management of the service were available. However, these were not consistently maintained or available to ensure care workers would always have clear guidance in emergencies and operational procedures would be kept under review and improved as needed.

People, their relatives and professionals told us the home was a safe place to live. Though people consistently told us they felt safe, we found people did not always receive the appropriate care and support they required to keep them safe. People's risks of falling out of bed and the risk to people from using equipment were not routinely assessed to ensure it was used safely. Medicine recording arrangements were not sufficiently robust to prevent errors occurring so that people would receive their medicine as prescribed.

Care workers had received training in safeguarding and were able to demonstrate an awareness of abuse and how concerns should be reported.

There were sufficient care workers to support people's needs and keep them safe. However, the required information relating to care workers employed at the home had not always been obtained when care workers were recruited to evidence safe recruitment practices had been followed. Care workers received training and supervision and they told us they received sufficient support and guidance to enable them to fulfil their roles effectively.

People were supported to stay healthy. Care workers identified when people became unwell and worked closely with the local GP surgery and other health professionals. People and their relatives were complimentary about the food served at the home. People were supported to eat and drink enough to meet their needs.

We were concerned that opportunities and appropriate support had not been provided for people to be involved in decisions about their care and that their rights under the Mental Capacity Act 2005 had not been upheld. Where the provider placed restrictions on people to keep them safe, they were waiting for legal authorisation instructing them to do so. The registered manager could not show restrictions were only placed on people as a last resort after less restrictive approaches had been exhausted. There was a risk that people's rights might not be upheld and restrictions might be placed on people unlawfully, whilst the registered manager awaited the outcome of Deprivation of Liberty Safeguarding (DoLS) applications.

People's needs were generally assessed and their care planned. Care workers knew people's needs, what was important to them and their preferences well. However, the care records we saw were disorganised, confusing and did not always contain up to date daily care records to support care workers to provide consistent care.

People and their relatives and visiting professionals were complimentary about the quality of care provided. They liked the friendliness of staff, and the homely atmosphere. People we spoke with commented positively about the staff and how they were cared for. We saw instances of caring interactions between staff and people. We observed staff offer reassurance to people when they were providing support and promoted independence.

People who used the service had written information about the formal complaints process available in their care file. There had been no complaints since our previous inspection. People and relatives were encouraged to give their views about the service. However, their feedback had not been used to make significant improvements to the quality of activities provided to people.

People's care had not been planned to ensure opportunities were created for people to engage in meaningful activities, maintain their social skills and pursue their interests. We were concerned that some people who were at risk of loneliness and boredom might not receive the support they required. We have made a recommendation about involving people in activity choices and supporting them with meaningful activities.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe

Robust processes to ensure people's risks were assessed and managed appropriately required further development. When bedrails were used guidance was not available to ensure these were used safely and appropriately.

There was sufficient staff to meet people's needs. However, the required information relating to staff employed at the service had not always been obtained.

Although we found only one medicine administration error, people's medicine records were not always sufficiently robust to prevent errors from occurring.

Is the service effective?

Requires improvement

The service was not always effective.

Where there were concerns about people's capacity to consent to decisions about their care, the provider did not follow appropriate guidance when making decisions in people's best interest. The decision to apply for a DoLS had not been made in accordance with the principles of the Mental Capacity Act 2005.

Training was provided for staff, both mandatory and in key areas. Staff received supervisions to support them to reflect on and develop their practice.

People's nutritional needs were assessed and monitored, with a choice of

regular meals provided.

People were supported to stay healthy. Care workers quickly identified when people became unwell and promptly involved the relevant health professionals.

Is the service caring?

Good

The service was caring.

People gave positive comments about staff, the care they received and how they were cared for.

We saw positive interaction and communication between staff and people when providing support. People felt, and observations showed, how privacy and dignity was maintained.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's needs were generally assessed and their care planned, but the care records we saw were disorganised and confusing. People were not always involved in regular, formal reviews of their service and their care records had not always been updated to reflect people's changing needs.

People didn't always have access to opportunities for social stimulation or activities that met their individual needs and wishes. We have made a recommendation about involving people in activity choices and supporting them with meaningful activities.

A complaints process was in place and an annual satisfaction survey was completed. However, relatives' feedback regarding the lack of activities had not led to improvements.

Is the service well-led?

The service was not always well- led

Effective management and governance systems were not in place. Shortfalls had not always been identified so that actions could be taken to address these in order to drive service improvements.

Records relating to the management of the service were not always completed. Records such as people's behaviour support plans and the service emergency plan were not always maintained or available.

Care workers were clear about their roles and responsibilities in providing care to people and found the registered manager approachable and supportive.

Care workers demonstrated the provider's values of respect and treating people as individuals when supporting people. Care workers were given opportunities to influence improvements in the home.

Requires improvement

Ridgemede Care

Detailed findings

Background to this inspection

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

The inspection took place on 4 and 5 August 2015 and was unannounced.

On the first day, the inspection team consisted of two adult social care 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. The expert by experience had experience in older people's care services. On the second day of the inspection, the inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (information about important events which providers are legally required to notify us by law) and other enquiries from and about the provider. We contacted commissioners of the home for any relevant information they held.

We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

During the inspection we spoke with 14 people who lived at the service and seven relatives/visitors. We undertook informal observations and spent time with people in communal areas to observe the care and support being provided.

We spoke with the registered manager, Operations Manager, the Project and Quality Assurance consultant, one team leader, four care workers, the chef and maintenance person. We spoke with the district nurse and with nursing practitioner form the local GP practice.

We viewed a range of records about people's care and how the service was managed. These included the care records for six people, all the medication records, recruitment records for four staff members, policies and procedures, audits and meeting minutes.

At the last inspection on 31 May 2013 the service was meeting the essential standards of quality and safety and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

We looked at the arrangements in place to manage risk, so people were protected and their freedom supported and respected. We looked at the care records relating to two people who used bedrails when in bed. Ridgemede Care used bedsides attached to profile beds. Risk assessments had not been completed to identify these people were at risk of falling out of bed and care workers could not tell us why one person required the use of bedrails. It was not clear from speaking to care workers and the registered manager what other options had been explored and how the decision had been made that bedrails would be appropriate to reduce people's risk of falling out of bed. Bedrails had not been checked to ensure they met the requirements for safe use, as described by the Health and Safety Executive (HSE) and guidance was not available to care workers detailing the measures required to keep people safe when using bedrails. The registered manager told us she would address these safety concerns immediately.

Risk assessments detailed some measures to keep people safe from falls and the use of hoisting equipment, however these required further development. The risk assessments for people using hoists to transfer from bed to chair were general and did not detail people's individual risks for example, relating to their willingness to use a hoist, the reassurance they might need or any aspect of their skin frailty that might need to be taken into account to prevent bruising. One person's mobility risk plan was contradictory and it was not clear from their plan what equipment they were using at the time of our visit. We saw the community occupational therapist (OT) was working with the service to re-assess people's moving and positioning risks. The registered manager had ordered new equipment as recommended by the OT to support people safely. The registered manager assured us that people were safe. However, there was a potential risk of people not being kept safe because the provider had not always identified, assessed and managed risks relating to the health, welfare and safety of people.

We looked at the arrangements in place to ensure the safe management, storage and administration of medicines. We observed the senior care worker administering people's evening medicines. The senior carer did this safely and people's medicines were given in accordance with prescription and not signed for until they had been successfully administered. We noticed that care workers made sure the senior care worker was not disturbed and interrupted during the medicines round, which decreased the risk of errors or mistakes being made. We looked at the storage arrangements for medicines. The medicines storage fridge temperatures had not been recorded daily in accordance with the provider's medicines procedure. The effectiveness of people's medicines might have been compromised as it was not clear from the records that medicines had been stored within the recommended temperature ranges.

Apart from one person, people's medicine administration records (MAR) were up to date and showed that medicines had been administered in accordance with people's prescriptions. This person had not received their pain medication and could have been in significant pain. The registered manager told us they would take immediate action to ensure the person received their missed medicine. Though people's MARs were up to date, we found some aspects of recording related to medicines and the MARs could be improved. For example, there were some unexplained gaps on the MARs relating to discontinued medication and handwritten prescription instructions were not being checked and countersigned by a second staff member as recommended by National Institute Clinical Excellence (NICE) guidelines on medicines. The record of quantities of medicines received or carried over in the past month were not available, meaning that a full audit of stock against the MARs was not possible. Staff would therefore not be able to judge from the records whether people had received sufficient medicine stock to ensure they would receive their medicine as prescribed in the coming month. Some people at the service were prescribed medicines on an 'as required' (PRN) basis. However, there was no information in the care plans or medicine records we looked at to guide staff on what the medicines were for or how decisions about their use should be made. People might therefore not have consistently received their PRN medicine when required.

People, their relatives and professionals told us the service was a safe place to live. One person said "Safe? Absolutely, I like it here very much". A relative told us "I never see anyone being treated badly, I've never seen bruises, never see any signs of unkindness. There always seems to be enough staff and they're all lovely". People were

Is the service safe?

encouraged to share any safety concerns and they told us they would be confident speaking to a member of staff if they had any concerns. We observed that people looked comfortable and relaxed with the staff and with each other.

Though people consistently told us they felt safe, we found people did not always receive the appropriate care and support they required to keep them safe. People's risks of falling out of bed were not always appropriately assessed and the risk to people from using bedrails was not routinely assessed to ensure they were used safely. Medicine recording arrangements were not sufficiently robust to prevent errors from occurring so that people would receive their medicine as prescribed. These safety concerns are a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure staff were recruited safely and people were protected from unsuitable staff. Although recruitment checks, such as proof of applicants' identity, investigation of any criminal record, and declaration of fitness to work, had been satisfactorily investigated and documented, two of the four recruitment files we reviewed did not show evidence of full employment history. There were gaps in employment history, or dates of previous employment only stated the year of employment, which meant months may be unaccounted for. We found the provider's application form in use did not prompt applicants to provide a full employment history and a written explanation for gaps. Though staff and the registered manager told us applicants attended an interview to determine their suitability no interview records were available to evidence how the registered manager had judged applicants to meet the requirements of the role.

We found that the registered manager had not protected people by ensuring that the information required in relation to each person employed was available. This is in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had policies and procedures for safeguarding people against abuse and we saw these documents were available and accessible to members of staff. This helped ensure care workers had the necessary knowledge and information to make sure people were protected from abuse. The staff were aware of who to contact to make referrals to or to obtain advice from at their local safeguarding authority when responding to allegations or suspicions of abuse. The registered manager said abuse and safeguarding was discussed with staff on a regular basis during supervision and staff meetings. Care workers and records confirmed this to be the case.

Care workers told us and records confirmed they had received safeguarding training within the last year and they felt confident in whistleblowing if they had any worries. Whistleblowing is a way in which staff can report misconduct or concerns they have within their workplace. The registered manager told us there had been no safeguarding concerns since our last inspection.

Regular health and safety checks were carried out to ensure the physical environment at the service was safe for people to live in. Maintenance staff carried out a set programme of weekly and monthly health and safety checks. Water temperature of baths, showers and hand wash basins were taken on a monthly basis to ensure they were within safe limits. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, gas cooker, fire, fire alarm and fire extinguishers. The lift and hoists were serviced by independent contractors in line with the manufacturer's guidance. Staff had received refresher training in the home's fire safety procedures and people's personal evacuation arrangements the week before our visit. The fire officer had also visited the service and the registered manager told us he was satisfied with the service's fire risk assessment and evacuation procedures. The fire officer was supporting the registered manager to review the arrangements for people who required support to evacuate the service if there was a fire. The provider had identified work was needed to the kitchen area to support effective infection control and plans were underway to refurbish the kitchen within the next six months.

There were enough staff to meet people's needs and keep them safe. We saw all public areas were within eyesight of a care worker and they checked regularly whether people were safe or needed support. People and relatives told us people did not have to wait too long when requesting assistance from care workers. Call bells were within people's reach and when used promptly answered by care workers. People benefitted from care workers who had worked at the service for several years and knew people well and anticipated their needs so that support was available at the right time. The provider was recruiting to fill

Requires improvement

Is the service safe?

two vacancies left by care workers who had retired. Care workers were working extra hours to cover these vacancies but told us they were managing with the extra shifts and had no concerns about the staffing levels.

We discussed how staffing levels were determined with the registered manager. She confirmed though no formal staffing tool was used, staffing was adjusted according to people's needs. Rotas showed additional care workers were deployed during busy times in the day and care workers confirmed additional staff were made available when people were unwell.

Requires improvement

Is the service effective?

Our findings

Appropriate arrangements were not in place to ensure people's legal rights were protected by proper implementation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA sets out what must be done to make sure the rights of people who need support to make decisions are protected, including how to make lawful best interest decisions on behalf of people who lack capacity.

The registered manager had made a number of decisions about people's care without recording people's involvement and those of their representatives in their decision making. This included the use of bedrails, adjusting the time people spend in communal areas and supervising people for their safety who tried to leave the service. These decisions had been made on people's behalf without completing a mental capacity assessment to show people lacked the capacity to make these decisions themselves. Care workers and the registered manager could not describe how these best interest decisions had been made in line with the MCA Code of Practice. Care workers had received training on the MCA. They understood the need to get consent from people before supporting them and the need to assess people's mental capacity if they suspected they were unable to make a decision. However, care workers involved in making decisions about people's care, were not always able to describe what an assessment would look like and how a decision should be made in someone's best interests. We found no examples of completed mental capacity assessments and best interest decisions and the provider did not have a system for recording these. We were concerned that opportunities and appropriate support had not been provided to people to be involved in decisions about their care and that their rights under the MCA had not been upheld.

Four applications had been made to the local authority to deprive people of their liberty under the Deprivation of Liberty Safeguards (DoLS). One emergency application had been authorised and three applications were awaiting review by the local authorities. The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. These safeguards are designed to protect people by ensuring if there are restrictions on their freedom these need to be authorised by the local authority who will assess whether the restrictions are needed and lawful. Though the registered manager had made DoLS applications to the local authority she had not assured herself that people could not agree to these restrictions before asking relatives to agree to the DoLS. The registered manager could not show restrictions were only placed on people as a last resort after less restrictive approaches had been exhausted. There was a risk that restrictions might be placed on people unlawfully while the registered manager awaited the assessment from the local authority to determine whether the restriction was needed and lawful.

Where there were concerns about people's capacity to consent to decisions about their care, the provider did not follow appropriate legal guidance. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us care workers understood their needs and we saw care workers were competent and confident when supporting people throughout our visit. Professionals and relatives told us care workers knew how to support people appropriately.

Care workers told us they received training tailored to people's needs and mentoring to ensure they knew how to effectively support and care for each person's needs. Most of the training was delivered by an external training company and the registered manager attended the training to ensure it met the needs of staff and was of a high quality. Outside specialists were brought in to deliver training where appropriate. Care workers had received training from the NHS Continence Advisor in June 2015 and told us this had helped them understand how to use people's prescribed continence aids effectively. The had also visited the home in July 2015 to train care workers in the use of new moving aids and will continue to provide training on the new equipment. All training was classroom based to give care workers an opportunity to share their experience and be actively involved in discussions. Care workers told us this interactive training had enhanced their learning.

Care workers told us they received sufficient training to undertake their role effectively and training records showed all care workers were up to date with training considered to be mandatory by the service. The registered manager had reviewed the induction programme to link to the new Care Certificate. The Care Certificate sets out learning outcomes, competences and standards of care

Requires improvement

Is the service effective?

that care workers are nationally expected to achieve. This ensured people received effective care from care workers who had the necessary level of knowledge and skills. Care workers had benefitted from the support and regular visits by the local GP practice's nurse practitioner. Care workers gave examples of how the nurse practitioner's guidance had developed their understanding of people's diabetes and mobility care.

Care workers told us they felt well supported and that they had received supervision. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. We saw records to confirm that supervision had taken place. The registered manager had also presented learning sessions for the team including care planning, nutrition and the new fundamental care standards to support their learning.

People were supported to maintain their health, including access to specialist health and social care practitioners when needed. People told us they could see a doctor or nurse any time they needed to. The two health care professionals we spoke with told us they did not have concerns about people's wellbeing, the service worked closely with them as health professionals and implemented their guidance appropriately. For example, the visiting district nurse told us care workers informed them in a timely way when people required blood tests and assisted people as needed during her visit. The nursing practitioner told us ''Staff are very good at asking for advice, they always alert me when people are not eating well or there is any redness on their skin''. We saw records to confirm that people had visited the GP, dentist, optician, chiropodist and mental health professionals as required.

People and their relatives were complimentary about the food served at the service. Comments included ''The food is brilliant'', ''The chef is very obliging, he helps everyone with what they want'' and ''There are good roasts over the weekend''. The chef knew what people liked and didn't like and the main afternoon meals were prepared from a list of people's favourite meals. Nobody asked for an alternative meal during our visit but these were available on request. During the afternoon care workers came round with a list of three light meal alternatives for the evening meal and people were supported to make their choice. The lunch mealtime was calm, sociable and people told us they enjoyed their meal. Most people ate independently and appropriate support was provided to those who required assistance during meal times.

People who were at risk of choking had been assessed by the community Speech and Language Therapist (SALT). We observed people being supported with pureed meals and thickened drinks in line with the SALT recommendations. The provider had introduced new nutritional screening tools to identify specific risks with people's nutrition. Care workers and the nurse practitioner told us staff monitored people's weight for losses and increases and alerted her of any concerns. Care workers were still developing their skills in using these tools to inform people's care plans and keeping people's weight records up to date to ensure they reflected the care people had received

Good

Is the service caring?

Our findings

We looked at the arrangements in place to ensure the approach of care workers was caring and appropriate to the needs of the people.

The people and their relatives were complementary about the care workers. They felt care workers would speak to them in passing and would get something for them if requested. Comments made by people included "The carers are all very good, friendly and helpful", "You can't fault them – any of them. It's a really nice place." and "Staff will do anything for me; always smiling." One relative told us ""Staff are very kind, caring and helpful" and another "Staff are universally lovely."

We observed interactions between care workers and people and they were patient, supportive, kind and friendly. We saw care workers sharing more than a quick greeting with people in bed or in their armchairs. Care workers could describe how they supported people with limited verbal communication skills with hand gestures and simple sentences to make their wishes known. Care workers responded promptly to people requesting assistance and they did so in a patient and attentive way. We observed care workers interrupting what they were doing to attend to people's requests and giving them the time they needed for reassurance.

Care workers showed they had good relationships with people, speaking about them warmly showing that they held them in high regard. They also demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were. Care workers showed respect for people by addressing them using their chosen name, maintaining eye-contact and ensuring they spoke to people at their level, seated and not rushed.

Care workers showed compassion and kindness towards people. For example, when one person became upset staff comforted them promptly and tenderly by speaking with them in a soft voice and sitting with them till they felt better. Each person had a designated key worker with particular responsibility for ensuring the person's needs and preferences were known and respected by all staff. The key worker engaged with the person in whatever way was most appropriate to them. This helped ensure consistency of care and that people's daily routines matched their individual needs and preferences.

Care workers treated people with dignity and respect and supported them to maintain their privacy and independence. We observed care workers speak to people in a respectful and caring manner and were sensitive to people's moods and feelings. When people needed support staff assisted them in a discrete and respectful manner, for example when people needed to use the bathroom. When personal care was provided this was done in the privacy of people's own rooms. Each person had their own individual bedroom where they could spend time in private when they wished.

People were supported to maintain relationships with their relatives and friends. Relatives were encouraged to visit as often as they were able to and relatives were supported to take part in people's care, for example supporting them during meal times if people preferred.

Requires improvement

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure people received person-centred care that had been appropriately assessed, planned and reviewed. Person-centred planning is a way of assisting someone to plan their life, time and support, focusing on what's important to the individual person.

Each person had a file containing assessments and care plans and some reviews of their care. Generally the records contained information about each person and their care needs. However, these had not always been promptly reviewed and we found instances where people's needs had changed but this had not yet been reflected in their support plans. The daily handover meeting did not provide care workers with detailed information about people's changing needs. We found care workers were the key source of information about people's support guidance. Care records were confusing and disorganised. For example, care workers had not updated care plans when changes had been noted in reviews and evaluations. This meant that unless you read the original care plan and all of the following reviews and evaluations you could not be sure that you had all of the up to date information about the person's care.

The use of a variety of nutrition and moving and handling risk screening tools was confusing for care workers. One person required staff to complete a food and fluid monitoring chart to be able to inform the nurse practitioner whether they were eating and drinking sufficient amounts. These daily records had not always been completed as required. The care plans of people whose behaviour might cause themselves or others discomfort did not always provide sufficient guidance to enable to care workers to know how to reassure people and actively create social opportunities for them. For example, one person's care plan referred to their social inclusion plan but the registered manager could not find this care plan. The standard of the care records meant that there was a risk of people's needs not being identified, supported or monitored accurately by care workers.

We found that the registered manager had not protected people from the risk of unsafe or unsuitable care by maintaining an accurate, complete and contemporaneous record in respect of each person. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers knew people's needs, what was important to them and their preferences well. We heard many examples of how staff supported people according to their wishes, these included people's food choices being catered for. One relative said ''He always likes an egg and toast in the morning and they always make sure he gets it''. People's rooms were personalised and decorated with the objects they valued. It was noted in some people's care plans that they like to be well-dressed and we saw care workers supported them to maintain their appearance and visit the hairdresser. A daily newspaper was made available to those people who had requested it. Holy Communion was provided by a local vicar monthly for people who wished to attend.

The registered manager said they operated an open door policy. People and their relatives were actively encouraged to feedback any issues or concerns to them directly or to any member of staff. The provider had a complaints process in place. This was provided to people on arrival at the service and included the telephone numbers of organisations to contact and who to complain to including the local authority and the Care Quality Commission. The registered manager told us there had been no complaints during the last 12 months at the service. People and their relatives told us they knew how to complain. One relative said ''I do not need to complain because when I suggest anything that could be improved they act on it very quickly. I said I would like my loved one to get out a bit more and they organised a volunteer to do that''.

Relatives were asked to give their feedback about the service through completion of an annual satisfaction survey. The May 2015 survey results showed relatives were generally happy with the care provided. The registered manager had made some improvements following this survey including fitting suggestion boxes for people, care workers and residents to give feedback as well as ensuring people received their newspapers. However, relative's feedback had not consistently been used to make improvements to the service. For example, in the survey completed in 2014 relatives said they wanted to see more opportunities for people to engage in activities in and outside the home. This continued to be a theme in the

Requires improvement

Is the service responsive?

2015 survey with relatives saying they would still like to see more activities for people. Though the provider had asked relatives for their views they had not always acted on their feedback and made the requested improvements to the activities available to people.

People gave us mixed feedback about the opportunities for structured and meaningful activity in the home. People who preferred spending time on their own with occasional interaction told us they were satisfied with the level of activity provided. However, people who could not independently make their way to communal areas, preferred one to one activities or were experiencing eye or hearing loss did not always get the opportunities to enrich their lives with the things they liked to do. One person told us ''I get lonely sometimes'' and another that they got bored. We were concerned that some people who were at risk of loneliness and boredom might not receive the support they required. It was not clear from people's care plans how they had been supported to make or participate in making decisions relating to the way they would like to spend their time in the service.

The previous activity coordinator left the home a year ago and while some activities still occurred, these were not frequent and usually involved visiting singers, reminiscence speakers, ad hoc quiz or bingo sessions or similar. One care worker had recently completed activities co-ordinator training and the registered manager told us she was working with the care worker to develop a structured activity programme for the home. We saw the care worker had planned recent trips to the seaside and more events were being planned.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their activity preferences and supporting them to engage in meaningful activities, maintain their social skills and pursue their interests.

Requires improvement

Is the service well-led?

Our findings

At the time of our visit a full and effective governance system to monitor the quality of the service and the risks to the health and safety of people was not in place. The registered manager was able to demonstrate that some quality audits had been undertaken within the last year and was able to describe some improvements made following the newly introduced medicine and infection control audit. However, these audits were still new to the service. The manager had complete one cycle of audits and told us she was still making adjustments to the audit forms and mentoring staff to complete these appropriately. Regular follow-up checks had not been undertaken to ensure actions identified following the medicine audit including, the newly introduced fridge temperature monitoring chart, were being implemented correctly.

Records relating to the management of the service were not always completed. For example, an infection control audit had been introduced in June 2015. The audit record had not been fully completed and there was no resulting action plan highlighting any actions required, the responsible person and timescale to ensure the identified improvements would be achieved. Care workers and the registered manager could describe the service emergency plan including if the lift was to break down, but this had not been recorded and did not constitute a full and effective procedure and risk assessment that care workers could easily reference. Staff might therefore not respond to emergencies consistently to ensure people remained safe.

Checks had been undertaken to ensure the safety of the environment. However, a formal system was not in place to support the registered manager to audit whether these safety checks had been completed appropriately. Areas for improvement had not been identified so that this could be fed back to the relevant staff to drive improvement and ensure learning from mistakes. For example, staff undertook fire emergency evacuation exercises. However, the outcome was not recorded and the registered manager could not tell us if improvements were required to ensure people were supported appropriately during a fire evacuation.

We saw there were policies and procedures available to inform and guide staff and people using the service. However, these did not include the use of bedrails, how to monitor people for injury following falls or how to record MCA assessments and best interest decisions. We noted the registered manager was reviewing the use of MCA assessment forms in the home, however, this work had not been completed. This meant staff may not have up to date information about current best practice to ensure people's needs would be assessed and their care planned consistently.

Records and systems for reporting, investigating and acting on incidents of concern were not robust. Accidents or incidents were documented on a standardised form. Action taken in response to incidents was not always clearly recorded and signed off by senior staff. Incident forms were not routinely audited by the registered manager to ensure staff had correctly implemented the accident/incident procedure.

The registered manager told us the local authority's quality improvement service visited the home on 7th April 2015 as part of the provider's external quality monitoring arrangements. Records of this visit showed that the provider was made aware of similar concerns to those we found relating to incident records and consent procedures. However, at the time of our visit these concerns had not been effectively addressed.

The registered manager told us she was aware that improvements were needed in relation to the care plan format and activities and was starting to introduce some audits to ensure this. We saw she spent significant time familiarising herself with national good practice guidance and had begun to implement these in the home, for example introducing the new Care Certificate and nutrition guidance. A Project and Quality Assurance consultant had been employed to support the improvements required. The registered manager had taken some action to address the concerns she identified such as introducing an additional care worker to administer medicine in the busy morning period. However, in the absence of a robust governance system the provider's efforts had become fragmented and action plans had not been drawn up, completed and monitored for their effectiveness to ensure improvements would be made consistently.

The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

On the first day of our inspection people's care records were not kept securely in the office. People could not always be assured that their personal care records had been kept securely and their confidential information only accessed by staff with the authority to do so. We discussed this with the registered manager and saw on the second day of our visit records were stored securely.

Care workers demonstrated a sense of pride in their work and strived to enhance people's lives in line with the provider's stated objectives. These included promoting people's independence and treating each person as an individual. Care workers, relatives and people described the culture in the home as ''people centred'', ''very supportive'', ''kind and considerate, like a family'' and ''always wanting to provide people with the best care''. The registered manager kept the values and culture of the home under review and this was evident in her concern for staff' wellbeing and the value based approach when recruiting new staff.

People and relatives were not always aware who the registered manager of the home was and what their role in the day to day running of the home was. They perceived the senior carers as being in charge of the home and were complimentary about their leadership. One relative told us ''The seniors are always here, quick to respond if I have concerns and always keep me updated about any changes''. Care workers told us they were clear about their roles and responsibilities in providing care to people and found the registered manager approachable and supportive. The registered manager took care worker's views into account and had made improvements following their recommendations. For example, the purchase of a new medicine trolley to enable care workers to clearly see all medicine for each person.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment because risks to people had not been assessed and mitigated. Equipment was not monitored to ensure it was used safely. Medicine records did not support the proper and safe management of medicines. Regulation 12 (1) and (2) (a) (b) (e) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where there were concerns about people's capacity to consent to decisions about their care, the provider did not follow appropriate legal guidance Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not protected people by ensuring that the information required in relation to each person employed was available. Regulation 19 (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not protected people through good governance systems. The registered person had not ensured peoples' records accurately reflected the care delivered to them. Regulation 17 (1) (2)(a)(b)(c)