Lambton House Ltd

Lambton House

Inspection report

New Lambton
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Tyne And Wear
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Tel: 01913855768

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31 August 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 24 and 31 August 2016 and was unannounced. This meant the staff and registered provider did not know we would be visiting.

Lambton House was last inspected by CQC on 30 June 2015. The location was rated Requires Improvement in all five domains. An inspection visit took place on 26 November 2015 to follow up on the risks in relation to people who had diabetes and found that the registered provider had followed their action plan and had made improvements at the service. We checked the remaining actions during this inspection visit.

Lambton House provides care and accommodation for up to 49 people with personal care needs. On the day of our inspection there were 48 people using the service, some of whom had a dementia type condition.

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

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and staff, and described potential risks and the safeguards in place. Staff had been trained in how to safeguard vulnerable adults. Medicines were stored safely and securely, and procedures were in place to ensure people received their medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and training sessions were planned for any due or overdue refresher training. Staff received regular supervisions and appraisals.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following the requirements in the Deprivation of Liberty Safeguards (DoLS).

The registered provider had followed their action plan and made improvements to the home to make it more dementia friendly, and plans were in place to continue to improve the environment.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service, and family members, were complimentary about the standard of care at

Lambton House. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they moved into Lambton House and care plans were written in a person centred way.

The registered provider protected people from social isolation however more activities could be provided during the day to stimulate and entertain people who used the service.

People who used the service, and family members, were aware of how to make a complaint and did not raise any concerns during the inspection visit.

Staff felt supported by the registered manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service. Family members told us the management team were approachable and understanding.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the registered provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people and staff.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

Staff supported people at meal times and were aware of people's dietary needs.

People had access to healthcare services and received ongoing healthcare support.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

The service incorporated environmental aspects that were dementia friendly. Plans were in place to continue to improve the environment for people with dementia.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

Care records were up to date and regularly evaluated.

The home had an activities plan in place however more activities could be provided during the day to stimulate people.

The registered provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The registered provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the local community.

Lambton House

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

This inspection took place on 24 and 31 August 2016 and was unannounced. This meant the staff and registered provider did not know we would be visiting. One Adult Social Care inspector and an expert by experience took part in this inspection. 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 we visited the service we checked the information we held about this location and the registered provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with four people who used the service and five family members. We also spoke with the registered manager, deputy manager, one senior care staff and three staff members.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also carried out observations of staff and their interactions with people who used the service.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at Lambton House. They told us, "'I feel as if she is safe. They are checked during the night, I quite like that", "I looked for a home and when I looked here I liked the girls. As long as she's safe and happy, which she is here" and "I feel she's safe here. It's lovely and clean and the staff are all over here".

People who used the service told us, "At night everything is locked up and you're not worried about somebody walking in" and "You feel quite safe".

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the registered manager and looked at staff rotas. The registered manager told us it had recently been identified that staffing levels at night needed to increase due to the individual needs of the people who used the service. Night staffing levels were increased from four to five care staff and feedback to the change had been positive. The registered manager told us staff absences were usually covered by their permanent staff however they did have access to one bank staff member and agency staff were only used if the absence could not be covered by permanent staff or bank staff. Staff we spoke with did not raise any issues regarding staffing levels.

A person who used the service told us, "In the past there wasn't [enough staff] but there is now."
Family members told us there was enough staff to care for their relative safely. They told us, "The place is crawling with staff" and "There seems to be loads of staff, they are always very busy".
Family members felt that staff responded to requests for assistance quickly. They told us, "You ring the bell and they are here straight away" and "Their response time is good". This meant there were enough staff with the right experience and knowledge to meet the needs of the people who used the service.

The home is a detached, two storey building set in its own grounds. Entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. Appropriate personal protective equipment (PPE) and hand washing materials were in place and available. The registered provider had an infection control policy and a 'Control of infection and reporting of infectious diseases' procedure in place. We saw a copy of the most recent infection prevention and control visit report for Lambton House and saw from the follow up visit that all actions had been

completed. PPE training was regularly carried out and records were maintained to show which staff had received the training and when. Infection control observations were carried out on staff every six months and no concerns were raised from any of the observation records we looked at. This meant people were protected from the risk of acquired infections.

Risk assessments were in place for people who used the service and described potential risks, how likely the risk was to occur and the actions taken to reduce the risk. Risk assessments included falls, falling out of bed, use of the nurse call system, weight loss, malnutrition and skin damage. Monthly reviews were carried out and were up to date.

At the previous inspection it was identified that the registered provider did not have risk assessments in place to ensure people used the stairs in a safe way. During this inspection visit we found risk assessments were in place for people who used the stairs. Actions taken to reduce the risk to people using the stairs included carpets, lighting and handrails to be well maintained, people to wear correctly fitting footwear and staff to assist wherever possible.

Risk assessments were in place for bedrooms and identified potential hazards to people who used the service and staff. These included slips and trips, burns and scalds, objects falling from height, window maintenance and restrictor checks, poor lighting, room and water temperature and emergency call systems. Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014).

Equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, an up to date fire certificate of inspection was in place, checks of fire escape routes, fire warning systems and firefighting equipment were carried out every two months. Personal emergency evacuation plans (PEEPs) were in place for people who used the service. PEEPs ensured staff knew what steps to take to ensure safe evacuation from the building in the event of a fire. This meant the registered provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

We saw a copy of the registered provider's safeguarding adults' policy and procedure. The procedure described the actions to be taken by staff, visitors and family members if they observe or suspect abuse may have taken place. The registered provider's safeguarding file included a copy of the local authority safeguarding adults' partnership risk threshold tool and policies and procedures. We saw records of safeguarding incidents and statutory notifications had been submitted to CQC in a timely and appropriate manner. We found the registered provider understood the safeguarding procedures and had followed them.

Accidents and incidents had been recorded and each record included details of the person who had the accident, the person filling in the accident record, when and where the accident occurred and how the accident happened. The 'Accident analysis file' had a section for each person who used the service, which meant a history of the person's accidents was at hand and any trends could be identified. Accident analysis forms were completed for each accident and described the action taken, outcome and any follow up actions.

At the previous inspection it was identified that people's medicines were not always administered in a safe way. During this inspection we looked at the management of medicines at Lambton House. Medicines were

stored in a locked treatment room. Two locked trolleys were secured to the wall. Storage cupboards were also locked, one of which contained the controlled drugs cabinet. Controlled drugs are medicines which may be at risk of misuse.

Regular temperature checks were carried out of the treatment room and locked refrigerator. Temperatures were within recommended levels.

A medicine administration record (MAR) was in place for each person who used the service. A MAR is a document showing the medicines a person has been prescribed and records when they have been administered. Each person's MAR included an up to date photograph of the person, whether the person had any allergies and a PRN protocol record, where applicable. PRN medicines are "as required" medicines and are not given as a regular dose or at specific times. The PRN protocol included the person's details, the name of the medicine, the route of administration, dosage, interval times between doses, the desired outcome of taking the medicine and review date.

We saw the most recent 'Pharmacy advice visit', carried out on 26 April 2016, included checks of policies and procedures, ordering and receipt of medicines, storage of medicines, storage of controlled drugs, disposal of medicines and administration of medicines. No safeguarding issues or issues that required following up urgently were identified as part of this visit.

Monthly medicine audits were carried out by one of the management team. The most recent was carried out on 24 August 2016 and included an audit of the supply of medicines, levels of support, administration, recording, controlled drugs, disposal, homely remedies and self-medication. Any issues were recorded and actions put in place, for example, working with the GP surgery regarding some stock ordering problems.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. Family members told us, "[Name] is always clean" and "It's good because they know what [Name] wants". Another family member told us how living at the home had reduced a person's health risks. They told us, "[Name]'s been here nearly three years and had no UTIs [urinary tract infections] or falls, which she had lots of at home."

Staff at Lambton House completed mandatory training, which included fire safety, infection control, safe handling of medicines, food safety, mental capacity, first aid, moving and handling, safeguarding and nutrition. Mandatory training is training that the registered provider thinks is necessary to support people safely. We saw from the training file that staff had recently completed training in the Deprivation of Liberty Safeguards (DoLS) and equality and inclusion. Refresher training for moving and handling was booked for September 2016.

New staff completed an induction to the service. This included an introduction to the organisation, conditions of employment, introduction to the home and the role, health and safety, policies and procedures, and education and training. All new staff were enrolled on the Care Certificate unless they already have relevant qualifications. The Care Certificate is a standardised approach to training for new staff working in health and social care.

Staff received regular supervisions and competency assessments in the workplace. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff at Lambton House received themed supervisions, which included medicines, moving and handling, philosophy of care, nutrition and hydration, pressure care, equality and diversity, safeguarding, communicating with people and dementia. Staff also received annual appraisals.

The local NHS Foundation Trust carried out an annual focus on under nutrition review on 8 June 2016, which reviewed practices relating to nutrition in the home. The review found the home was fulfilling the required standard. We saw a recent food hygiene certificate, which showed the home had been given the top rating of five by the local authority on their food hygiene visit.

People had nutritional care plans in place, which included a 'Focus on under nutrition nutritional assessment' and a malnutrition universal screening tool (MUST). MUST is used to identify people at risk of under nutrition. We saw one person was at high risk of under nutrition due to being bedbound and having an illness that meant the person found swallowing difficult. The person's nutrition care plan described that the person was unable to feed themselves, all meals and drinks were to be given with assistance from staff and fluids documented on a fluid balance chart. The care plan was reviewed monthly and charts were up to date. We saw a record of a referral to the speech and language therapy team (SALT) for this person regarding their swallowing difficulties. Recommendations made by SALT were incorporated in the person's care plan, for example, normal diet, small sips from an open cup and assistance from staff.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining rooms at meal times when required. People were supported to eat in the lounge or their own bedrooms if they preferred. We asked people about the food. They told us, "It's not tip-top but its edible", "It's not too bad", "We don't go hungry. On the whole it's good" and "If you say can I have a salad they will give you one". Family members also told us the food was good and some had eaten meals at the home. One family member told us, "I tried a cheese pie and the pastry was delicious". A family member also described a "tea-on-your-lap day" and told us, "The food was well presented."

Two family members told us their relative had put on weight since living in the home. One said, "[Name] has put on weight since she lived here. That's a good thing." Another family member explained how when a meal had gone cold as the person had taken so long to eat it, staff took it away and brought a fresh meal.

Family members also described regular snacks outside of mealtimes via a serving trolley. One family member told us, "There are always teas, coffees and biscuits given out and they have a sandwich in the afternoon." Another family member told us, "In the summer they have ice lollies and drinks." This meant people's dietary needs were addressed.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, occupational therapists and physiotherapists.

Some of the care records we looked at included emergency healthcare plans (EHCP). These included information to help communication in an emergency, for example, if the person was admitted to hospital. Information included GP contact details, diagnosis and medicines.

Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. For example, one person's EHCP stated a best interest decision meeting had taken place with the family and the person was not to be readmitted to hospital.

Care records included copies of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These DNACPRs were up to date and had been reviewed as required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had been trained in mental capacity and DoLS. The service kept a record of people who had DoLS in place, the date the DoLS was authorised and when it was due to expire. We saw copies of DoLS applications and statutory notifications had been submitted to CQC. Copies of authorisations were kept in people's individual care records. This

meant the registered provider was following the requirements in the DoLS.

We observed that the service had sought consent from people for the care and support they were provided with, for example, consent to be checked hourly or more frequently if required.

Some of the people who used the service were living with dementia. At the previous inspection visit it was identified that there was a lack of a dementia friendly environment in the home. During this inspection visit we found the registered provider had followed their action plan and had made improvements at the service. Dementia friendly signage had been put in place in corridors and on doors, corridors were clear from obstructions and well lit and hand rails contrasted with walls. Photographs of people had been put on their bedroom doors and we saw one person had added a photograph of a dog and other items to their door. This helped people with dementia orientate around the home. One corridor in the home included photographs of famous music and movie stars however there was very little interesting memorabilia or artwork on display in other corridors or in the lounges.

A questionnaire completed by a family member on 19 August 2016 suggested memorabilia, such as pictures of miners, or tactile objects, such as beads and buttons, be placed on walls so there were things for people to look at or touch. We discussed this with the registered manager, who had taken note of the family member's suggestions and told us they were working with organisations to make the home more dementia friendly. They also told us a new activities co-ordinator had been recruited and part of their role would be to develop the environment and dementia friendly activities. The registered manager also told us that improvements to the internal décor of the building were going to be made once the external decorating was finished. This meant the service incorporated environmental aspects that were dementia friendly and plans were in place to continue to improve the environment for people with dementia.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Lambton House. People told us, "It's very nice. The people are friendly and the staff are nice" and "They are very caring, even through the night". Family members told us, "She's looked after and that's the most important thing", "They [staff] are very empathetic towards them", "They are all very caring" and "The main reason [Name] is here is down to the staff".

A family member described where a staff member took their relative to hospital and said that they liked the way the staff member spoke to their relative saying, "It's not demeaning or patronising, they are on a level."

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. For example, we observed one staff member talking to two people, encouraging them to go to the lounge to take part in activities. This was done in an encouraging and friendly manner.

The registered manager told us they had introduced staff to the "6Cs". The 6Cs, care, compassion, competence, communication, courage and commitment, focus on putting the person being cared for at the heart of the care they're given. We saw staff members had completed 6Cs 'Promise cards' and had described what they were going to do to implement the 6Cs into their care practice.

We asked people and family members whether staff respected the privacy and dignity of people who used the service. A family member told us staff were "Caring and gentle" and protected their relative's privacy and dignity. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care.

Recent questionnaires completed by people who used the service and family members asked whether privacy and dignity was maintained and confidentiality respected at all times. The five questionnaires we looked at, which were completed in August 2016, all stated, "Yes" or "Always". People and family members also said they were satisfied with the level of care provided.

Care records showed how people's privacy and dignity were to be respected. For example, "[Name]'s privacy and dignity is to be maintained at all times" and "[Name]'s wishes and choices are to be respected at all times". This meant that staff treated people with dignity and respect.

Care records showed how people were supported to be independent. For example, "[Name] is encouraged to remain as independent as possible" with aspects of their personal care, and "[Name] is to be encouraged to choose their own clothing each morning".

We saw evidence that people had been involved in writing their care plans and their wishes were taken into consideration, for example, we saw the care records included a section where the person could say what

name they preferred to be called.

Care records also included evidence of personal choice. For example, "[Name] is a very private person and prefers the assistance of a female carer", "[Name] prefers a bath to a shower", "[Name] does not like water on their hair and may become anxious when having their hair washed" and "[Name] is a smartly dressed person, who always wears co-ordinated clothing". This meant that staff supported people to be independent and people's personal preferences were taken into consideration.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The registered manager and deputy manager told us none of the people using the service had advocates however information on advocacy was made available to people and family members.

None of the people who used the service were receiving end of life care. However, staff had received end of life care training. People had 'In the event of a death' forms completed in their care records. These provided information on the person's wishes, including, funeral details, religion and personal effects. This meant people had been able to be involved in their end of life wishes.

Good

Is the service responsive?

Our findings

The service was responsive. Care records were up to date and regularly evaluated.

Care plans were in place and included personal hygiene, dressing, mouth care, mobility, sleep, nutrition, continence, skin integrity, medication, communication, cognition, behavioural, spiritual and activities/stimulation. Care plans were reviewed monthly and six monthly.

People's needs were assessed before they moved into Lambton House. This ensured staff knew about people's needs before they moved in.

'Service user's details on admission' sheets recorded important information about the person, such as, preferred name, religion, and next of kin and GP contact details. 'Relevant history' sheets recorded people's medical history and other relevant information. For example, any current diagnosis, previous medical conditions or injuries, whether a DoLS was in place, communication and vision difficulties and specific care needs.

One person's relevant history sheet stated the person was unable to weight bear, required two care staff for assistance with personal care, required two hourly re-positional changes, half hourly checks and one care staff to assist with all meals and drinks. The person had a care plan in place for skin integrity, which described how the person was at risk of skin tears and skin breakdown. Staff were directed to observe the person's skin for any discolouration, breaks to the skin and skin tears and report concerns to the senior care staff, who would inform the district nurse if necessary. The person also had an associated risk of skin damage risk assessment in place and a Waterlow pressure ulcer prevention/treatment policy in place. Monthly care plan and risk assessment reviews were up to date

'Day and night reports' and 'Key carers reports' were written by staff to summarise care and update on people's health. Records recorded whether repositioning had been carried out, fluids had been encouraged, visits by healthcare professionals and bed time routines.

Family members were largely complimentary about the care at Lambton House and told us they felt involved in the day to day care of their relatives. They told us, "When she fell they called me straight away, within an hour" and "They noticed a problem with [Name]'s eye before me and acted upon it". Another family member gave an example of being involved in getting a special bed for their relative. Other family members could not recall being involved in care planning and reviews but did say they were kept informed if anything had happened in the home.

Some of the people who used the service had a 'Detailed social assessment' in place. This provided information on the person's family and friends, birthdays, music and activities the person enjoyed, food and drink likes and dislikes, health, and religious and spiritual needs.

We looked at what the registered provider did to protect people from social isolation. People who used the

service told us, "I don't think we are bored here" and "We just sit and watch TV". When prompted for other examples this person told us there were, "Quizzes, bingo and singers."

Family members told us, "[Name] just stares into space or walks around" and "I feel the staff are so busy. They haven't got time [for activities]". A family member told us that people who used the service did go out into the garden and gave examples of bingo, a singer and a person with a ukulele coming into the home to entertain the people who lived there. Another family member told us, "I think [Name] has communion once per month and the hairdresser is in every week."

Staff we spoke with told us there was a vacancy for an activities coordinator however the previous activities coordinator still worked at the home and carried out activities with people as part of their role. Staff also gave examples of entertainment that came into the home such as singers and pets as therapy (PAT) dogs.

On the first day of our inspection, we observed significant periods of time where people were sitting in lounges with only the TV for stimulation and there was often no staff available to support conversation. However, on the second day of our visit we observed staff in the lounge areas engaging people in conversation. We discussed activities with the registered manager and deputy manager. They told us they had recognised they needed to improve the activities on offer at the home and had recruited a new activities coordinator, who was going through recruitment checks at the time of our inspection. Discussions had been held with the new activities coordinator and planned events included movie evenings and social events with family members.

The registered manager and deputy manager told us it had been identified through observations and discussions with people and family members that the preferred time for group activities was late afternoon and early evening, after people had tea. For example, a singer had come to the home the previous week and people were offered alcoholic drinks and snacks during the evening to make it like a social club event. The home had a games cupboard and people enjoyed playing games in the evening. The registered manager told us magazines and newspapers were delivered for people who wanted them and the registered provider's minibus would also be used more often to take people out on excursions and trips to the seaside. The minibus was previously predominantly used for the registered provider's day care service however this provision had been reduced so the minibus was available more often to be used by residents.

We saw events planned for September included singers and entertainers, and a company providing exotic animals were visiting the home. This meant activities were in place to protect people from social isolation however more activities could be provided during the day to stimulate and entertain people who used the service.

The registered provider's complaints file included a copy of the registered provider's complaints procedure. This provided information of the procedure to be followed when making and receiving a complaint. For example, who can make a complaint, how to make a complaint, how the complaint would be dealt with and what to do if the complainant was not satisfied with how the complaint was dealt with. There had been two complaints recorded in the previous twelve months and we saw details of the complaint and copies of correspondence between the registered manager and the complainant. People, and their family members, we spoke with were aware of how to make a complaint. This showed the registered provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager and deputy manager about what was good about their service and any improvements they intended to make in the next 12 months.

Family members felt confident in their relative being in the home and liked the atmosphere. One told us, "[Name] used to attend the day centre so it was a natural progression". Another told us, "[Name] is familiar with this area so feels comfortable here. I chose here because [Name]'s always been part of the community". Family members also described liking the "feel of the home" and several family members commented positively on the way staff interacted with people. Family members knew the name of the registered manager and said the registered manager was "approachable."

Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. This meant the service had a positive culture that was person centred, open and inclusive.

Staff were regularly consulted and kept up to date with information about the home and the registered provider. We saw records of staff and senior staff meetings, which included staff signature sheets. The most recent senior staff meeting had taken place on 23 August 2016 and the agenda included DoLS, care documentation, visit documentation, accidents, staffing and handovers, nutrition and any other business.

A staff satisfaction survey had taken place in November 2015, which asked staff whether they were happy with their hours and staff rota, whether the staff worked as a team, suggestions to improve the service and environment, organised events and any other comments. The registered manager had produced a feedback report from the results of the survey, which included actions to address the points that had been raised. For example, extra sets of keys had been cut for staff to save time and certain staff members were given the responsibility to take care of the keys when on duty.

The service had links with the community, particularly the local church and schools. The registered manager and deputy manager told us school children visited the home, for example, at harvest festival and Christmas. A local public house had contacted the home offering to host afternoon tea events for people in residential care in the local area. A local community centre also held afternoon tea and other community related events. The registered provider's minibus was going to be used to transport people to these events.

At the previous inspection visit it was identified that the registered provider did not always have in place accurate and complete contemporaneous records including a record of the care and treatment provided to each service user. During this inspection we saw that the registered provider had an appropriate system in place and care records were up to date, and regularly reviewed and evaluated.

We noted that records were kept securely and could be located when needed. This meant only care and management staff had access to them ensuring people's personal information could only be viewed by

those who were authorised to look at records.

We looked at what the registered provider did to check the quality of the service, and to seek people's views about it.

The service had a 'Quality assurance action plan' in place, which was to be carried out on a two monthly basis. This included general housekeeping, laundry, kitchen, bedrooms, equipment and wheelchairs. We saw copies of inspection forms where these checks had been recorded and where issues had been identified, actions had been carried out. For example, air conditioning installed in the kitchen, a leaking water pipe in the main corridor was in the process of being repaired and the decorating of two bedrooms. Records we saw were up to date.

Quality assurance audits were carried out by the registered manager. We looked at the most recent audit on 29 July 2016, which recorded that all audit checks had been completed, maintenance and repairs were up to date, gas safety, bath hoists and lift inspection checks had been carried out, the annual fire service check was due in August 2016 and decoration was planned for inside the home once all external paintwork had been completed.

Care plan audits were carried out on a regular basis and included a check of pre-assessments, social assessments, care plans, monthly and six monthly reviews, risk assessments, inventory, professional visits, wishes in the event of death, photographs, contracts, weight records and PEEPs. Any actions were recorded, for example, one person's care plans were awaiting family signatures and information in the event of death.

Monthly pressure relieving cushion and mattress audits were carried out. We looked at three people's records on 22 August 2016 and saw the audits included checks of internal and external covers, foam, frames and bed rails, where applicable. All cushions and mattresses were cleaned daily and covers were removed and deep cleaned on a weekly basis.

Although family members we spoke with could not recall residents' meetings taking place, we saw meetings were held at the home to give people who used the service the opportunity to feed back on the quality of the service. The last recorded meeting was on 20 May 2016 and agenda items included the home's refurbishment, activities, and food and drink.

'Service users/relatives questionnaires' were carried out annually. We saw copies of the surveys, which included questions on the atmosphere of the home, whether staff were approachable, satisfaction with the care provided, the décor and cleanliness of the home, the quantity and variety of food on offer, choice of activities, meetings, privacy and dignity, and any concerns, improvements that could be made or other comments. We saw the registered manager had responded to any issues raised.

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.