GrayAreas Limited

Kingsmount Residential Home

Inspection report

30 Kingshurst Drive
Paignton
Devon
TQ3 2LT

Tel: 01803663460
Website: www.kingsmount.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7 and 10 December 2018 and the first day was unannounced. At the last inspection in April 2016 the home was rated as good in key questions 'Safe', 'Effective', 'Caring' and 'Well Led'. The home was rated requires improvement in 'Responsive'. At this inspection, we found that the key questions 'Responsive' had improved to good but the key questions of 'Safe' and 'Well Led' were now rated as Requires Improvement.

Kingsmount Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kingsmount Residential Home is registered to provide care, nursing and accommodation to a maximum of 32 older people, some of whom may be living with dementia or memory loss. At the time of the inspection, there were 31 people living at the home.

At the time of the inspection there was no registered manager in post. The provider had employed a new manager who had started at the home two days prior to the inspection. The new manager was an experienced care home manager and they told us they would be submitting an application with the Care Quality Commission to become the registered manager of the home. The new manger was supported during this inspection by the deputy manager and the nominated individual. The report refers to them as 'the management team'.

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.

Risks to people were assessed and risk assessments tools were used to identify common risks such as those relating to falls, skin integrity and medication. However, daily monitoring records did not always show that care was being delivered as it should. Equipment used to minimise risk was not always set correctly in order to reduce the risk of skin damage.

Where people were at risk of dehydration, fluid monitoring charts did not indicate if action had been taken or guidance sought when a person had consistently not reached their target intake amount.

Improvements were required to ensure that medicines were managed safely. Whilst medicines were stored and administered safely, random sampling of five medicines found discrepancies with the stock levels of three medicines. Other aspects of medicines were managed safely

Systems and processes in place to monitor the quality and safety of the home failed to identify and address the issues we found during this inspection.

People told us staff supported them with kindness and respect. Comments included, "They are very caring here", "Staff are on hand and we can call them anytime, they have been as good as gold" and "They've always been kind to me, it feels safe here." Staff respected people's privacy and dignity and interacted with people in a caring, compassionate and professional manner. People were encouraged to be as independent as possible but where additional support was needed this was provided.

People told us they felt safe when they received care and support from staff at the home. One person told us, "It's very clean here, and safe." A relative said, "I sleep at night because they look after mum so well." People were protected from the risk of abuse because staff understood how to identify possible abuse and were clear in how they would report this. Staff told us they had received safeguarding training.

People were supported by staff that had been recruited safely and had sufficient knowledge and skills to enable them to care for people. There was a comprehensive staff training programme in place and staff told us they felt supported and received regular supervision. However, during the inspection we saw three recently completed appraisal forms were identical and not individualised for the staff members. We made a recommendation to the provider about ensuring appraisals were tailored to the individual staff member.

People and their relatives gave us a mixed response about there being enough staff. One person told us, "The girls don't really have time to speak to me sometimes, it's time that does it as they're so short staffed." Another person told us, "I use the call bell they don't take very long to come." Staffing rota's and observations during the inspection showed us there were sufficient numbers of staff to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way; the policies and systems at the home supported this practice. Where people lacked capacity to make specific decisions about their care and treatment, decisions had been made in their best interests. However, one person, who had been assessed as not having the capacity to decide about taking their medicines or the use of a sensor alarm mat placed in their room to keep them safe, did not have a best interests decision recorded in their records. This was addressed immediately. We made a recommendation to the provider to ensure that all assessments and best interests decisions are made in compliance with the Mental Capacity Act 2005.

People received support that was tailored to them as individuals and were supported by staff who understood their specific needs and how to support them in the way they wanted to receive care. People's records were comprehensive enough to give staff a good understanding of people's preferences and life experiences. This helped staff to support people to engage in meaningful activities that they enjoyed. Since the last inspection the home had worked very hard to improve the provision of one to one engagement and activities to reduce the risk of social isolation.

People living at the home, relatives and staff were happy with how the home was being managed. They found the management team and staff approachable. The provider regularly sought feedback from people living at the home and their relatives about the support provided. We saw evidence that the feedback received was used to develop and improve the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could not be assured risks to their health, safety and well-being would be managed safely.

Systems and processes in place to ensure the safe handling of medicines had not always been properly followed.

There were a sufficient number of staff employed to care for people and safe recruitment procedures were followed to make sure they were suitable to work with people living in the home.

Staff had been trained in safeguarding people and were knowledgeable about the potential signs of abuse.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to carry out their roles effectively.

The principles of the Mental Capacity Act (2005) were generally followed.

People told us the food was good and choices were available to them.

People's health and nutritional needs were regularly assessed, and referrals made to appropriate health professionals when necessary.

The premises were designed, adapted and decorated to meet people's needs and wishes.

Is the service caring?

Good

The service was caring.

People told us staff were always kind and caring.

People were treated with dignity and respect.

We observed good relationships between staff and people living in the home.

People were encouraged to retain an appropriate level of independence.

Staff supported people to maintain contact with their family.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care. Care plans included people's preferences and guidance on how they would like their care delivered to meet their identified needs.

People were supported to take part in activities they enjoyed.

There was a complaints system and people knew how to complain.

People were supported to have a dignified end to their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems in place to monitor the quality and safety of the service had not been used effectively; this had led to the shortfalls identified during this inspection.

People, their relatives and staff were positive about the leadership at the service. Staff felt supported by the management.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

The registered manager understood their regulatory responsibility and had submitted statutory notifications as required.

Kingsmount Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 10 December 2018. The first day of the inspection was unannounced. One adult social care inspector and an expert by experience attended the first day and one adult social care inspector returned for the second day of the 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 our inspection we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). Statutory notifications provide CQC with information about significant events such as allegations of abuse and serious incidents. The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

We spoke with eight people who used the service and three relatives. Due to their needs, some people living at Kingsmount were unable to share their views. We used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the new manager, deputy manager, the nominated individual for the service, kitchen porter, eight care staff, the activities co-coordinator and a visiting healthcare professional.

We observed care and support in communal areas, spoke with people in private and looked at the records for five people. We reviewed how medicines were managed and the records relating to this. We checked five

staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

After our inspection visit we contacted three health and social care professionals to gather their feedback and received feedback from two.

Requires Improvement

Is the service safe?

Our findings

We found that systems in place to ensure potential risks to people's safety and wellbeing had been considered and assessed were not always effective. We found individual risks had been recorded in people's care plans and management strategies had been drawn up to provide staff with guidance on how to manage risks in a consistent manner. Some people were at risk of skin damage. Actions to minimise the risk of harm included using specialist equipment such as air mattresses and cushions. However, when we checked three people's mattress settings we found pressure mattresses were not set correctly for the person's weight. For example, one person's last recorded weight on the 18 November 2018 was 35kgs, their mattress was set for a person that weighed between 70 and 140kgs. There was no guidance in care plans or risk assessments to instruct staff on what pressure the mattress should be set at and documentation of daily mattress checks had not been completed. These types of mattresses must be set at the correct pressure in order to reduce the risk of skin damage.

We brought these concerns to the attention of the management team who immediately responded by checking all mattresses in the home. The management team told us mattresses were visually checked daily by staff but acknowledged this had not been effective or recorded as it should. They said that following our findings, senior care staff would be responsible for checking and recording mattress settings daily, and all staff would receive a training update.

In addition to appropriate pressure relieving equipment used to reduce the risk of skin damage, risk assessments identified people required regular repositioning and prescribed skin creams applied to protect their skin. However, it was not clear that people were receiving the care they needed. For example, one person's care plan informed staff the person required a strict two hourly repositioning regime as they were at significant risk of pressure ulcers. Daily repositioning charts were used to document when staff had repositioned the person and what position the person had been moved to. Records showed the person's position was not being changed as required and stated in their care plan. On some days we saw there were gaps of up to five hours where it appeared the person's position had not been changed. Staff could not be assured that the person was receiving the care necessary to mitigate the risk of skin damage and their planned care was not being adhered to.

Another person's records identified staff should check their skin integrity and apply a prescribed skin protection cream. It was not clear that the person was receiving the care they needed. Records showed that between 16 November and 6 December 2018, a twice daily skin protection cream had not been applied on eighteen occasions. This meant the person may not be receiving the treatment prescribed for them and this could put them at risk of skin damage.

Where people were at risk of dehydration, charts were used to record what they had drank and how much. However, daily intake totals were not always added up and when they were they were not acted on. For example, one person's care plan told staff that they should be drinking 'as close to two litres as possible a day', their fluid recording charts for the two weeks prior to the inspection show that they had drank between 250mls and 1000mls each day. The fluid monitoring charts did not indicate if action had been taken about

poor intake, there was no evidence that staff had sought guidance when a person had consistently not reached their target amount. We were told that charts were not checked by the management team as part of an audit. We spoke to the management team who told us anyone recognised as not drinking enough were discussed with staff at handovers and staff were told to encourage them to drink more. Some staff handover records confirmed this.

Where people were living with long term health needs, records did not always contain enough information about how people were to be supported to reduce any risks and maintain their safety. For example, one person was living with seizures. Their care plan did not contain details about what staff should look out for regarding their seizure activity and what action they should take, such as recording and monitoring the seizures, when to give medicines or when it might be necessary to ask for additional medical support. This meant the person may be at risk from staff missing seizure activity resulting in a delay in the treatment or medicines they required to keep them safe. We saw seizure activity was recorded in care plan monthly updates in order to help medical professionals manage the person's symptoms.

One person was being supported with their continence needs and had a urinary catheter. We saw from records this person had experienced urinary infection and retention in the past. Their continence care plan did not contain detailed guidance for staff to recognise and prevent complications or infections. The care plan did not guide staff on what action they should take to minimise the risk and when to alert health professionals. This meant that the person may be at risk of recurrent urinary infections and their associated complications. We brought this to the attention of the management team. The new manager updated the care plan to include this information.

Improvements were required to ensure that medicines were managed safely. We looked at people's medicines administration records (MAR) and saw that these had been completed with no missing signatures. However, random sampling of five medicines found discrepancies with the stock levels of three medicines. Two medicines showed an overstock of one tablet and another person's diabetic medicine showed an overstock of 86 tablets. This may indicate that medicines had been signed for but not given, as they remained in the blister pack. This could put people at risk of complications from not receiving the medicines they needed to maintain their health.

We spoke to the management team about the stock discrepancies. The new manager told us they had completed an audit of the medicines the previous day but acknowledged they had not identified the stock discrepancies. They said they would look at their processes and would ensure staff checked boxed medicines as part of their medicines audit to reduce the risk of this happening again.

This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Although not all risks had been documented appropriately, other risk assessments had been undertaken to enable people to retain independence and make their own choices, whilst minimising risk. Risk assessment tools were used to identify common risks such as those relating to falls, skin integrity and medicines. Additional assessments of specific risks took place when this was relevant.

Risks, such as those linked to the premises, were risk assessed and agreed actions to minimise risk, were in place. Staff followed risk assessments which helped to ensure people were safe in their environment. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. The provider ensured equipment was safe for people to use. For example, we checked records of maintenance of hoisting equipment, and found this was up to date.

Other aspects of medicines were managed safely. We observed staff giving medicines safely to people during the inspection. Staff were polite, gained permission and signed the Medicine Administration Records (MAR) after giving people their medicines. Medicines were stored and disposed of safely. There was a system to report and investigate medicine incidents so learning took place to prevent reoccurrence.

People told us they felt safe when they received care and support from staff at the home. One person told us, "It's very clean here, and safe." A relative said, "I sleep at night because they look after mum so well."

The provider had a process in place for investigating and responding to safeguarding concerns. Staff demonstrated a clear understanding of safeguarding and they had received the appropriate training. We looked at the records for safeguarding concerns raised during 2018 and we saw they included information regarding the concern, copies of relevant information including minutes of any meetings, notes of any investigation and the outcome.

The provider had a robust recruitment process in place to ensure new staff had the appropriate knowledge and skills for the role. Records showed various checks were undertaken such as past work performance, fitness and character. There were also checks of the prospective staff's identity and a Disclosure and Barring Service (DBS) disclosure was completed. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people in care homes.

People and their relatives gave us a mixed response about there being enough staff. One person told us, "The girls don't really have time to speak to me sometimes, it's time that does it as they're so short staffed." Another person told us, "I use the call bell they don't take very long to come." Staff told us that they felt supported and there was enough staff. One staff member said, "We do try to help each other if we're short, staff do come in to cover shifts." Staffing rota's and observations showed us that there were sufficient numbers of staff to meet people's needs.

The provider had systems in place to report when an accident or incident had taken place and staff were aware of what to do and could explain this to us. We found that trends were being monitored as a way of reducing the amount of accidents and incidents within the home. The nominated individual checked on this as part of their monthly audits with the manager.

Throughout the inspection we noted the home was extremely clean and smelled fresh throughout. We saw staff using personal protective equipment when supporting people and staff had access to antibacterial hand sanitising gel. We saw staff received training on infection control. The management of infection control was an integral part of how staff ensured people were supported safely.

Good

Is the service effective?

Our findings

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked to see whether the service was working within the principles of the MCA and whether any DoLS authorisations to deprive a person of their liberty had been approved through the local authority. People's care plans identified whether they had the capacity to consent to living at the home. Where people lacked capacity to make specific decisions about their care and treatment, decisions had been made in their best interests and in consultation with the appropriate people. However, one person, who had been assessed as not having the capacity to decide about taking their medicines or the use of a sensor alarm mat placed in their room to keep them safe, did not have a best interests decision recorded in their records. We spoke to the management team about this and they said this would be addressed immediately. When we returned for the second day of the inspection, a best interests decision meeting had been held with the appropriate people involved and enquiries had been made to secure an appropriate independent advocate to act on behalf of the person.

We recommend the provider review all Mental Capacity Act records to ensure best interests decisions have been considered and recorded.

Where people required restrictions on their liberty to keep them safe from harm, for example, to prevent them leaving the home alone, Deprivation of Liberty Safeguards (DoLS) had been applied for and no one was having their liberty restricted unlawfully.

Staff understood the importance of helping people to make their own choices regarding the care and support they received. Throughout this inspection we observed staff obtaining people's consent before providing support to them and working within the principles of the MCA.

People and relatives told us they felt the staff were well trained. Staff told us they had enough training to provide people with effective care. One staff member told us, "We have Infection control, fire training every 6 months, manual handling, there's so much I've done here I can't remember it all, and its ongoing."

Staff completed regular training to ensure they had the knowledge, skills and support to carry out their roles. Staff training included a detailed induction programme, covering all training sessions the provider considered to be mandatory. This included, safeguarding, fire awareness, moving and handling and infection control and included time spent shadowing experienced staff. Training in dementia and behaviours which challenge had also been provided, to meet the needs of people living at the home. The

provider supported staff to work towards nationally recognised qualifications and all staff were supported to complete the Qualifications and Credit Framework (QCF) level 2 Diploma in Care.

Staff told us they felt well supported and were very happy working at the home. One staff member said, "They do look after their staff and are nice to work for." Staff received regular supervision, so they could discuss their performance and development needs with their manager. However, during the inspection we saw three recently completed appraisal forms were identical and not individualised for the staff members. The main purpose of appraisal is to give the staff member the opportunity to reflect on their work and learning needs in order to improve their performance. One staff member told us their recent appraisal did not discuss their performance in detail or what they may wish to achieve in the future. Another staff member told us they had discussed their QCF diploma course and further training but this discussion and any agreed actions, was not written on their appraisal form.

We brought this to the attention of the management team who immediately wrote to all staff to invite them to have individualised appraisals completed. Four appraisals were completed before the second day of the inspection.

We recommend the provider ensures that all staff have the opportunity to benefit from regular appraisal tailored to the individual staff member to discuss their performance and career progression.

Prior to moving into the home staff undertook a pre-admission assessment to assess people's support needs. The assessment process considered people's preferences, likes and dislikes along with the protected characteristics of the Equality Act (2010). Some staff had received equality and diversity training to ensure they understood how to protect people's rights and lifestyle choices. The registered manager and staff said people would not be discriminated against due to their disability, race, culture or sexuality.

People and relatives were complimentary about the meals provided. Comments included, "The food is very nice" and " Food is very good here, I'd say excellent. In the evenings we have all sorts of things. We definitely have choice." People benefitted from a full range and choice of good quality food and drinks. People's meals were presented attractively, and the dining experience was not rushed. Where people required support to eat or drink, they were well-supported at their own pace. Snacks and drinks were available throughout the day for people to help themselves to, promoting their independence. Care plans contained risk assessments and specific guidance for people requiring a modified diet or who had an unplanned weight loss. Where necessary people had been referred to professionals, such as speech and language therapists and/or dieticians.

People were supported to access health care appointments. One person told us, " [person's name] wasn't very well last night. Staff checked on him two or three times, then phoned the doctor who said to call an ambulance which was here in only a few minutes." Another person told us they saw a chiropodist regularly. Records showed people had also had access to a dentist and optician. Staff told us they worked closely with other organisations to make sure people received care and support that met their needs. For example, they regularly took advice from a health care team who specialised in reducing the risk of people falling.

People benefitted from a home that was well decorated and homely. Since the last inspection Kingsmount had undergone adaptation and redecoration of the main communal living area to improve accessibility and ensure the home was suitable for people living with dementia. People living in the home were involved in this process and took part in a vote to choose the colour scheme. Easy to read pictorial signage was used throughout the home to help people identify important rooms or areas, such as their bedroom, toilets and bathrooms, and communal areas. Walls were decorated in contrasting colours from the floor coverings to

make the environment more suitable for people living with dementia. We observed there were handrails to help people with mobility needs.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the standard of care provided. Staff were described as being kind, caring and considerate. Comments from people included, "They are very caring here", "Staff are on hand and we can call them anytime, they have been as good as gold", "They've always been kind to me, it feels safe here" and "Yes the staff are king to me. You've got some very caring carers here." Relatives told us, "Mum has been here almost three years now. The care she gets here is fantastic. It's very personal. I can see she loves the way the staff talk to her and tell her things. I have no concerns at all with leaving her here" and "Mums really happy here, I think I'm now the favourite son!"

Staff supported people with kindness, respect and compassion. People responded well to staff and there was an atmosphere of friendly affection. We observed genuine, warm, friendly interactions between staff and people regularly throughout the day. We observed appropriate physical contact being provided by staff, such as hand holding or placing their arm around someone whilst speaking with them, which was warmly received by the people they were supporting. On the day of the inspection we saw staff celebrating a person's birthday with them. The person had presents to open the chef had made them a homemade cake.

Staff were very knowledgeable about the people living at the home, and were able to talk about people's likes, dislikes, history and backgrounds. We saw this information was recorded in detail within care plans, so all staff could get to know each person as an individual. Staff told us they felt the information in the care plans supported them to develop caring relationships with people.

Staff engaged people in all decisions they were able to make and encouraged people's independence. People's care plans contained information about what they were able to do for themselves and how staff should support them. For example, one person was able to undertake aspects of their own personal care with prompting from staff. Staff knew how best to encourage this person and what support they needed in order to undertake these tasks independently. We observed people were supported to make decisions about day to day care, for example, what time they wanted to get out of bed, when they would like support with personal care, and where they would like to spend their time.

Throughout the inspection we observed that people's privacy and dignity was respected. We heard staff communicating with people with respect, using a gentle tone of voice and offering reassurance when this was needed. One person said, "They treat me with respect." All the staff we spoke with told us of the importance of respecting privacy and dignity. One staff member said, "It's extremely important. I always make sure that I knock on doors, close curtains when giving personal care and always offer them help discreetly." People and relatives we spoke with, confirmed privacy and dignity were respected and maintained.

People's bedrooms were decorated and furnished to reflect people's personal tastes. People were encouraged to have things which were particularly important to them and to have things around them which were reminiscent of their past.

We saw people were supported to maintain relationships with those close to them. The home had an open-door policy welcoming friends and relatives to the home. There were private spaces within the home such as a nicely decorated smaller lounge where people could meet with their family in private if they wished. Relatives told us they felt welcomed and able to raise any issue or concern.

Information, including about advocacy support, was available in the reception area. Advocates can represent the views of people who are not able to express their wishes, or have no family involvement.

Good

Is the service responsive?

Our findings

People received support that was tailored to them as individuals and were supported by staff who understood their specific needs and how to support them in the way they wanted to receive care.

Prior to moving to Kingsmount, people's support needs had been assessed to ensure staff would be able to support them effectively. Records showed that wherever possible people were involved in the assessment process with the support of their relatives where appropriate. Care plans reflected the information gained during the assessment process and were completed in a person-centred manner. People's preferences, likes and dislikes were clear throughout and details of friends and family members who were important to people, were documented. Care plans covered all aspects of people's daily lives and gave staff information about people and the support they needed from staff. For example, how staff could help a person with personal hygiene whilst ensuring they retained as much independence as possible.

The provider was compliant with the Accessible Information Standard (2016), which requires that people who have sensory impairment or a disability have information available for them about their care in a way they can understand. People's communication needs were assessed, and information provided to people in a suitable format such as large font or picture cards. One person's care plan prompted staff to use visual cues, such as writing things down and prompt cards, to help communication between them.

People's records were comprehensive enough to give staff a good understanding of people's preferences and life experiences. This helped staff to support people to engage in meaningful activities that they enjoyed. Since the last inspection the home had worked very hard to improve the provision of one to one engagement and activities to reduce the risk of social isolation. The home had recently employed an activities co-ordinator who was extremely enthusiastic about providing person-centred activity that was meaningful to the individual. They told us, "I really enjoy my job. It's really important to get people involved in what they want to do. I have brought in loads for people to do; games, magazines, art work. But most of the time people just what to sit and chat and have someone spend time with them." They went on to tell us how they used the information in people's care plans about their likes and dislikes, activities and hobbies they once enjoyed and experiences from their work life. For example, one person was a watercolourist but since they had grown older and physically frail they had been unable to paint. The activities co-ordinator brought in salt clay and they made clay stars together, which the person enjoyed. Another person was helped to reminisce about their work life. The activities co-ordinator found old black and white photographs of where they used to work, "The memories came flooding back. She really enjoyed telling me about where she worked and what she did. It made her very happy."

There was also an organised programme of entertainment and group activity, for example, musicians, singers, keep fit, animal visits, school and church choirs. Staff also involved people in group activities such as, bingo and games. Some people were accompanied by staff to go shopping. The activities co-ordinator told us they would like to develop and provide more opportunities for people to get out and about. The home had the use of a mini bus and wheelchair accessible car.

The provider had invested in technology to help people to socially interact. The nominated individual told us they had recently bought two 'tablets' for people to use during one to one time to play games or look up information and pictures. The provider had also bought a smart device for staff to create bespoke playlists for people to enjoy. People were helped to keep in contact with their families and friends through 'Skype'. The home also invited a pupil from the local school into the home to provide basic computer lessons for interested people.

People told us that there was plenty to do but if they did not want to take part then that was ok. Comments included, "There is entertainment here but I choose not to go down. I'm not fussed about going out. I could do if I wanted to" and "We had pet afternoon yesterday, I had a dog sitting on my lap and I even touched a snake and a lizard. It was very popular the lounge was very busy everybody seemed to enjoy it." Another person told us, "They had a children's school choir in yesterday. I told staff that we'd love to go down but we couldn't as [name of person] wasn't well. Somebody must have told the teacher as they came up and sang to us in our room."

The complaints procedure was clearly displayed in the home and also included in the service user guide. People told us they knew what to do, should they have any concerns or complaints and that where they had raised concerns, these had been dealt with effectively. Comments included, "I usually talk to the staff and they sort things out" and "I would speak to one of the staff if I had any concerns." The home recorded any complaints received, which detailed who had complained, the nature of the complaint and the action taken to address this. Two minor complaints had been received since the last inspection, both of which had been dealt with appropriately, with responses provided to the complainant.

People's end of life wishes were discussed with them and their needs and choices recorded in their care plans. This ensured that people's final days were as they wished for and their choices known and respected. The home had links with the local hospice and staff had received additional end of life care training sessions. Staff told us this had given them more confidence to have conversations with families about and during end of life care and build a good rapport.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality and safety of the home; however, these were not always robust nor effective because they had failed to identify and address the issues we found during this inspection. For example, audits were in place to ensure staff were using their pressure ulcer risk assessment tool appropriately. However, there was no oversight of charts staff used to record if and when people had been turned as they should and as documented in their care plan. There was no audit or management oversight to ensure people's pressure relieving mattresses were set at the correct level, people were receiving their prescribed skin creams or if people had been drinking enough to ensure their health and wellbeing. Medicine audits had failed to identify incorrect stock balances.

Checks of people's care plans had failed to identify where records did not always contain enough information about how people were to be supported to reduce any risks and maintain their safety. For example, people living with seizures or a urinary catheter.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection there was no registered manager in post. The provider had employed a new manager who had started at the home two days prior to the inspection. The new manager was an experienced care home manager and they told us they would be submitting an application with the Care Quality Commission to become the registered manager of the home. The new manger was supported during this inspection by the deputy manager and the nominated individual. 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.

We found the management team open and transparent and willing to make the improvements necessary to improve recording of care at the home.

Audits in place included health and safety, infection control and cleanliness, medicines, monthly clinical audits and fire safety. The nominated individual attended the service weekly to discuss the service provided with the management team which included looking at any issues, complaints and examine call bell response times. They also completed quarterly audit of the service. Action plans were completed to improve the care provided which also fed into their yearly service improvement plan.

People and their relatives were complimentary about the management of the home. One relative told us, "It's brilliant here. The staff seem to know what they are doing and that's down to good leadership. There is a consistency of good practice and I would not hesitate to recommend the home."

The provider's philosophy of care was to provide a happy comfortable home with a principle aim to ensure "A supportive social environment where attention paid to dignity and quality of life is paramount."

Throughout the inspection we saw staff demonstrating this in the care and the compassion they showed to the people living in the home. There was a positive culture and a good staff morale.

There were clear line of responsibility and staff were supported to do their jobs through supervisions and appropriate training. Staff told us the new manager and management team were approachable and made themselves available in the home, should staff need them or wish to raise concerns. One staff member said, "The management is absolutely brilliant, if I have a problem I feel I can go to them and the seniors are all approachable." Another staff member said of the new manager, "[new managers name] is always saying 'thank you', she's lovely."

Staff told us they felt valued and the provider was nice to work for. One said, "They look after us. I'm paid for staff meetings that I attend, and we're paid for lunch time. Every month we have a staff meeting and if you're not on shift you get paid. NVQ meetings are also paid for."

Staff had the opportunity to participate in team meetings and share information so they were involved in the way the service was provided. One care worker said about team meetings, "We communicate through team meetings every month and have a staff handover every day. They are valuable. It's all about team work and communication."

People and relatives had the opportunity to give feedback and share their views with the provider about the service they received through a number of ways including questionnaires, online feedback websites and speaking individually with people. For people who might find completing a questionnaire difficult, relatives or other independent people were asked to complete them with people. Comments from the last questionnaires completed in 2017, included, "Helpful staff. Staff are lovely", "First class", "Staff do a good job, helpful and pleasant" and "The staff listen."

The new manager was aware of the legal responsibilities in notifying the CQC of significant events and incidents within the home. Notifications received were detailed and showed that action was taken to meet people's needs and risks were managed. The provider was aware of the legal requirement to display the registration certificate and rating from this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately managed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure the quality and safety of the service.