St. Martin's Care Limited

Windermere Grange Care Home

Inspection report

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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

We inspected Windermere Grange Care Home on 18 and 21 October 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

At the last inspection on 29 July, 11 and 28 August 2015 we rated Windermere Grange Care Home as requires improvement. We found that the lack of effective oversight meant that for a number of months the home had ran below the staffing levels required from the provider's own dependency tool. The process for analysing accidents and incidents needed to be improved in order to allow staff to identify trends and any preventative action that could be taken in the home. Alongside this, the audits failed to identify when care records were not accurately reflecting people's needs; that Deprivation of Liberty Safeguard authorisations and the associated conditions were not reflected in individuals' notes and staff were not contacting GPs to follow up changes in medication.

The registered provider sent us information to detail the actions that would be taken to make the necessary improvements.

Windermere Grange is a purpose built care home providing care for up to 72 people. The ground floor accommodates older people and since the last inspection a separate unit has been developed for people with a learning disability. The first floor accommodates older people living with dementia. All bedrooms are single occupancy with en-suite facilities and there are a number of lounge and dining areas.

The home has a manager in post who became the registered manager in September 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People who used the service and their relatives told us the staff were always very busy supporting people so had limited time with each individual. We visited from the early hours of the morning and spent time with people in each of the units. We found that the 68 people who used the service required varying levels of support. Staff worked hard to support people safely but staffing levels were not always sufficient to provide effective care. When we arrived to begin the inspection we saw staff were busy assisting people to get up and have their breakfast. Staff did not always have time to complete their support of one person before helping another. For example, we saw one person sitting in a bathroom with the door open as the member of staff helping them had been called away to assist someone else. We found that the staffing levels needed to be reviewed to ensure staff could also meet demands through the night and have time to complete all of their tasks.

At the last inspection when we reviewed the dependency tool, we found this to be extremely difficult to use and were unable to determine how staffing levels were calculated. However, the registered manager

confirmed that the staffing levels had been below those set out by senior managers in the organisation. Since the last inspection the previous operational manager had reviewed the registered provider's staffing calculation tool. A new tool had been developed but not implemented so staff remained reliant on the previous one. The new operational director told us that ensuring staffing levels consistently met people's needs, was an area they were working on as a priority.

Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards training and clearly understood the requirements of the Act, which meant they were working within the law to support people who may lack capacity to make their own decisions. However, staff were unclear about how to fill in the recently introduced Mental Capacity assessment forms. The registered manager had identified that staff needed additional support to ensure they had the skills and knowledge to consistently work with the Mental Capacity Code of Practice. They had organised training for staff around capacity assessments.

Following the last inspection a member of the public shared with us information from the Ombudsman and their investigation of the events leading up to the death of their relative in 2013. Following the review of the complaint the Ombudsman found that the home needed to make improvements to the way in which night time check records were completed as it could not be established the times of the checks. We looked specifically at the information staff now recorded around checks made during the night and found an accurate record was maintained.

At the last inspection we found that some improvements were needed in the way the staff managed medicines. We found that one person had not received appropriate pain relief as staff had not collected the person's prescription in a timely manner. At this inspection we reviewed the systems for the management of medicines and found that people received their medicines safely and on time.

People's needs were assessed and care was delivered in line with their individual care needs. The care plans contained comprehensive and detailed information about each person. However the complexity of the document and time constraints faced by staff led to not all of the support plans being updated in a timely manner. We discussed this with the registered manager and operational director who confirmed they had recognised the difficulties the current care records posed and so were in the process of introducing a new format. Following the inspection we were sent a copy of the new templates, which appeared easier to follow and less repetitive.

Staff had received a wide range of training, which covered mandatory courses such as fire safety as well as condition specific training such as dementia and diabetes. The operational director told us that not all of the staff had received refresher training but they had contracted a new training company to complete the annual training programme.

People we spoke with told us they felt safe in the home and the staff made sure they were kept safe. We saw there were systems and processes in place to protect people from the risk of harm.

People were supported to maintain good health and had access to healthcare professionals and services. People were supported and encouraged to have regular health checks and were accompanied by staff or relatives to hospital appointments.

People told us they were offered plenty to eat and assisted to select healthy food and drinks, which helped to ensure that their nutritional needs were met. We saw that individuals' preferences were catered for and people were supported to manage their weight and nutritional needs.

The interactions between people and staff were jovial and supportive.

People who used the service and staff were extremely complimentary about the support the registered manager provided and told us that they were always accessible and available to discuss any issues at the home.

We saw that the provider had a system in place for dealing with people's concerns and complaints. The registered manager ensured that concerns were thoroughly investigated. People we spoke with told us that they knew how to complain.

Effective recruitment and selection procedures were in place and we saw that appropriate checks had been undertaken before staff began to work in the home. The checks included obtaining references from previous employers to show staff employed were safe to work with vulnerable people.

Regular surveys, resident and relative meetings were held and we found that the information from these consultations were used to inform developments in the home such as the change in menus.

Checks of the building and maintenance systems were undertaken.

We found the provider was breaching one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the staffing. You can see what action we took at the back of the full version 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.

Staff were knowledgeable in recognising signs of potential abuse and reported any concerns regarding the safety of people to senior staff.

The registered provider needed to ensure there were sufficient skilled and experienced staff on duty to meet people's needs.

Robust recruitment procedures were in place. Appropriate checks were undertaken before staff started work.

Appropriate systems were in place for the management and administration of medicines.

Appropriate checks of the building and maintenance systems were undertaken, which ensured people's health and safety was protected.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to support people who used the service. They were able to update their skills through training.

People's needs were assessed and care plans were produced identifying how to support people who used the service.

Staff had improved their understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and how to apply the legislation.

People were provided with a choice of nutritious food, which they chose at weekly meetings. People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Good

This service was caring.

People told us that they liked living at the home. We saw that the staff were very caring and empathetic.

We saw that when staff had time they engaged people in conversations and these were tailored to ensure each individual's communication needs were taken into consideration.

People were treated with respect. The staff were knowledgeable about people's support needs.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were produced, which identified how to meet each person's needs. A new care record template was in the process of being introduced and this was less repetitive and easier to follow.

We saw people were encouraged and supported to take part in activities.

The people we spoke with were aware of how to make a complaint or raise a concern. They told us they had no concerns but were confident if they did these would be looked into and reviewed in a timely way.

Is the service well-led?

Requires Improvement

The service was not always well led.

A registered manager was in post. Staff and people who used the service told us they found the registered manager was very supportive and felt able to have open and transparent discussions with them.

The systems in place to monitor and improve the quality of the service provided were effective.

During the fortnight that the new senior management team had been in place they had identified gaps in practice and were taking action to address these, but not all of their checks covered all areas of practice.

Windermere Grange Care 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 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.

This inspection took place on 18 and 21 October 2016 and was unannounced and the team consisted of three adult social care inspectors.

The registered provider was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider completed the PIR in a timely manner.

Before the inspection we reviewed all the information we held about the home. The information included reports from local authority contract monitoring visits.

During the inspection we spoke with 12 people who used the service and three relatives. We also spoke with the operational director, the registered manager, the deputy manager, three senior carers, nine care staff, a domestic staff member and the cook.

We spent time with people in the communal areas and observed how staff interacted and supported individuals. We observed the meal time experience and how staff engaged with people during activities. We looked at nine people's care records, six recruitment records and the staff training records, as well as records relating to the management of the service.

We looked around the service and went into some people's bedrooms (with their permission), all of the bathrooms and the communal areas.

Requires Improvement

Is the service safe?

Our findings

At the last inspection when we reviewed the dependency tool, we found this to be extremely difficult to use and were unable to determine how staffing levels were calculated. The staff could not explain how they used the tool to calculate the number of staff needed for the whole home or each unit. Since the last inspection the previous operational manager had reviewed the staffing calculation tool used by the registered provider and had found it to be ineffective. A new tool had been developed but not implemented so staff remained reliant on the previous tool. The new operational director told us that ensuring staffing levels consistently met people's needs, was an area they were working on as a priority.

We asked people who used the service what they thought about the home and staff. The majority of people told us that they liked living at the home but noticed that staff were very busy. People said, "The staff are superb and you couldn't get better but they are rushed off their feet." And, "A friendlier bunch you won't meet anywhere else. They always go out of their way to make sure I'm ok and feeling on top form."

Relatives told us they had confidence in the staff's abilities to provide good care but had concerns about staffing levels. Relatives said, "The staff always do their best." And, "The staff are always very friendly and always keep me informed."

At the time of the inspection 68 people were using the service. During the day two senior care and seven care staff worked on the units for older people. The staffing levels on Coniston unit for people with a learning disability varied and could go from one senior and two care staff to one senior and four care staff. We could not determine why the levels of staffing varied on this unit. The registered manager told us that at the time of commissioning the Coniston suite they identified the need to allocate 55hrs per 24 hour period for the group of residents. But the registered manager recognised the difficulty posed by the way the current staffing rota was written.

Overnight there were two senior care staff and five care staff. We found that one staff member worked by themselves on the Coniston unit. We found the staff did not work as a team and told us they did not tend to ask staff on different units for assistance if they needed support. We found this pattern of working in isolation meant that insufficient staff were available to meet individuals' needs.

We observed practices at the home from 6.30am until after teatime and saw staff were constantly tending to tasks. Staff were very busy, and did not always have time to complete their support of one person before helping another. For example, we saw one person sitting in a bathroom with the door open as the member of staff helping them had been called away to assist someone else.

Another person had been involved in a serious incident the previous day. We had found that staff acted quickly to reduce the risk of harm to the person and had contacted the person's GP who had made a referral to the local mental health team and staff had also contacted the person's family. The care records showed the person had been placed on 30 minutes observations to check they remained safe. Prior to day staff coming on duty we observed this person's room for one hour and did not see any checks taking place. Staff

told us that with only one member of staff on duty in Coniston unit they could not always complete the 30 minute check.

Also we saw that staff did not always have time to sit and complete care records, which meant important information on people's support needs was not always recorded. For instance a person involved in the incident had not had their care records and risk assessments updated. We questioned the staff about this and they said they were intending to up-date the records that day, as they had previously not had chance. Staff were knowledgeable about people's support needs but details of them were not always fully recorded in care plans.

Staff made an effort to speak with people when they had time, but we saw that there were lengthy periods when people sat without any interaction with staff. For example, we completed a SOFI observation on the first floor and saw that three people in one lounge had no interaction with staff for 30 minutes, though staff did look into the lounge when passing to check that people were safe.

All of the staff we spoke with said more staff were needed, including care and housekeeping staff. One member of staff said, "There are not enough staff. We definitely need another one." When we asked another member of staff if enough staff were employed they shook their head to signal no. Another member of staff said, "I think we could do with another member of staff."

The impact of the current staffing levels was particularly affecting the care delivered at night on the learning disability unit. Staff told us, "We could do with another staff member at night. It's frightening sometimes. [Person using the service] needs one to one care and this takes me away from other people." Another staff member told us, "We need an extra member of staff at night. It is difficult to cover things such as breaks because staff are busy on the other units.

We observed that the staff member on night duty on Coniston had to leave the unit unattended as they needed to order breakfast for people. At this time there were three people in the dining room.

This was a breach of Regulation 18 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal Emergency Evacuation Plans (PEEP) were in place for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We noted that two 'grab and go' folders, containing PEEPs, were kept: one for the older people and one for the people who lived on the Coniston unit. We discussed this with the registered manager who told us that the peeps grab file is contained within a file called Emergency Grab File, which can be found in the manager's office along with the red Emergency Kit. We reviewed the document and found it was comprehensive and clearly set out the support each person needed.

Policies and procedures were in place to protect people from possible abuse. There was a safeguarding policy in place, providing guidance to staff on the types of abuse that can occur in care settings and details of how this should be reported. Staff we spoke with had a good understanding of safeguarding issues and said they would not hesitate to report any concerns they had. Where concerns had been raised records confirmed they had been investigated in a timely manner and referrals made to the local safeguarding team, where appropriate.

People who were identified to be at risk of harm had appropriate plans of care in place to ensure action was

taken to manage these risks. Risk areas included pressure relief, choking and making one's own tea with the kettle. Charts used to document change of position; food intake; and hydration were clearly and accurately maintained and reflected the care that we observed being given. This meant people were protected against the risk of harm because the provider had suitable arrangements in place.

Accidents and incidents were recorded and monitored, and remedial action taken where necessary to reduce the risk of them occurring again. For example, one person suffered a series of falls. Therefore increased observations and a referral to the falls team had the effect of reducing their number of falls. Accidents and incidents were analysed on a monthly basis to see if improvements could be made to keep people safe. The operational director discussed how they were introducing new tools that would further assist the provider to analyse incidents to determine trends and how they intended to use this to assist the manager to review the home.

Recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. We saw evidence to show that staff had attended interview and the registered manager had obtained information about them from referees. A Disclosure and Barring Service (DBS) check had been completed before they started work in the home. 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.

We saw that staff had received a range of training designed to equip them with the skills to deal with all types of incidents including medical emergencies. Staff confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. Staff were also able to explain how they would record incidents and accidents. A qualified first aider was on duty throughout the 24 hour period.

All areas of the service which we observed were very clean and had a pleasant odour. Staff were observed to wash their hands at appropriate times and with an effective technique that followed national guidelines.

We saw that personal protective equipment (PPE) was available around the home and staff explained to us about when they needed to use protective equipment. We spoke with the domestic staff who told us they had access to all the equipment they needed. We saw they had access to all the necessary control of hazardous substances to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

We saw records to confirm that regular checks of the fire alarm were carried out to ensure that it was in safe working order. We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and portable electrical appliances. This showed that the provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We saw that the water temperature of showers, baths and hand wash basins in communal areas were taken and recorded on a regular basis to make sure that they were within safe limits. We noted that the size of the bathrooms was limited and discussed that in future developments the registered provider may wish to consider how to provide more space in these rooms. We also noted some minor repairs were needed, which the maintenance person completed following our visit.

We found that there were appropriate arrangements in place for obtaining medicines, checking these on receipt into the home and storing them. We looked through the medication administration records (MARs) and it was clear all medicines had been administered and recorded correctly. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

Information was available in both the medicine folder and people's care records, which informed staff about each person's protocols for their 'as required' medicine. All staff who administered medicines had been trained and completed regular competency checks to ensure they were able to safely handle medicines.

Good

Is the service effective?

Our findings

People told us they were very satisfied with the care being delivered and thought the staff knew them well.

People said, "I am happy here and it is better than other places I have been." And, "We have a good life, they all go out of their way to look after us."

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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.

At the last inspection we found that staff were not aware of who was subject to Deprivation of Liberty Safeguard (DoLS) authorisations or if conditions were in place. At this inspection we found that the registered manager had ensured all of the staff were aware of who was subject to DoLS authorisations and any conditions associated with these authorisations. The registered manager had also put a system in place to monitor the DoLS authorisation forms being returned from the supervisory bodies and their expiry dates.

We had noted at the last inspection that the majority of the staff were unsure if a DoLS authorisation was needed for someone who has capacity. We found that a number of people who used the service had capacity so it would be inappropriate to apply for authorisations for these people. DoLS authorisations can only be used if the person lacks capacity to make decisions. A small number of the staff remained a little unclear as to whether these individuals would require DoLS authorisations. Again we explained to staff that the MCA requires that staff presume that people have the capacity to make decisions and people can agree to restriction unless an appropriate mental capacity assessment shows otherwise.

The care records we reviewed all contained an assessment of the person's capacity to make decisions. We found the templates directed staff to only complete them when evidence suggested a person might lack capacity, which is in line with the MCA code of practice. However, at times care staff were completing assessments for people they identified did not have a disturbance of the mind or brain. We discussed this mistake with the registered manager who undertook to re-check all of the assessments to ensure they were completed correctly.

We saw that care records sometimes showed that relatives and not the people they related to had signed

care plans. Where relatives made decisions the care records did not show whether relatives had become Court of Protection approved deputies, if they had enacted power of attorney for care and welfare or finance or if they were appointees to manage their relative' finances. Relatives cannot make decisions about care and welfare unless they have the legal authority to do so and the person lacks the capacity to make these decisions for themselves.

We discussed all of this with the registered manager and operational director who told us they were aware that some of the staff had not fully understood the MCA and DoLS training that had been provided.

The registered manager and operational director told us that in response to this gap in staff knowledge they were in the process of ensuring staff completed more in-depth training on the MCA and DoLS authorisation. The plan was for staff to complete other relevant training such as how to apply the Mental Capacity Act 2005 principles, how to complete capacity assessments, and obtaining consent in the next few months.

When people had been appropriately assessed as being unable to make complex decisions there were records to confirm that discussions had taken place with the person's family, external health and social work professionals and senior members of staff. This showed any decisions made on the person's behalf were done after consideration of what would be in their best interests. Best interest decisions were recorded in relation to care and support, finance and administering medicines amongst others.

We saw that lots of information was recorded in the daily records but staff did not appear to use this to assist them to evaluate whether the care plans remained appropriate. Generic care plans and assessments were used, which staff filled in but these did not prompt them to write pertinent information. We found that the complexity of the document and time constraints faced by staff led to not all of the support plans being updated in a timely manner. We discussed this with the registered manager and operational director who confirmed they had recognised the difficulties the current care records posed so were in the process of introducing a new format. Following the inspection we were sent a copy of the new templates, which appeared easier to follow and less repetitive.

We found that staff on the whole had a very good understanding of people's needs and had altered the way they worked but the care records did not reflect the actions they took.

All the staff we spoke with told us that they were supported in accessing a variety of training and learning opportunities. All the staff we spoke with were able to list a variety of training that they had received over the last year such as moving and handling, infection control and safeguarding. We confirmed from our review of staff records and discussions that the staff were suitably qualified and experienced to fulfil the requirements of their posts. Staff we spoke with told us they received training that was relevant to their role. We confirmed from our review of records that staff had completed mandatory training such as fire, infection control, first aid, medicines administration and other course such as nutrition and dementia care. We also found that the provider had completed regular refresher training for these courses but over recent months refresher training had not been available. The operational director explained that they had encountered problems in obtaining the required training courses so had contracted a new training provider. They were confident that all of the missed refresher training would be completed in the next few months.

Staff told us that they had received supervision sessions, which they found were informative and helpful. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Records were in place to confirm that supervision had taken place. We found that all of the staff had an annual appraisal. Staff told us that the new manager had held meetings with them and outlined what they would be doing to make changes to the home. The new registered manager showed us the minutes from

the meeting.

People were supported to maintain a healthy diet. When people started using the service their nutritional needs and preferences were assessed and plans put in place to support them. Kitchen staff were knowledgeable about people's nutritional support needs, and told us who received specialist diets such as diabetic or pureed food. People were regularly weighed and recognised tools such as the Malnutrition Universal Screening Tool (MUST) were used to monitor their nutritional health. MUST is a screening tool to identify adults who are malnourished, at risk of malnutrition (under-nutrition) or obese. It also includes management guidelines which can be used to develop a care plan.

The cook used a regular, four week menu to plan meals. This was sent around to people at breakfast time so they could choose what they wanted for lunch and dinner. However, the cook said people were free to eat whatever they wanted and could choose things that weren't listed on the menu. The cook added that they were responsible for ordering food supplies and were free to purchase anything that people requested.

Throughout the inspection we saw people were regularly offered hot and cold drinks and snacks. Most people chose to eat their meals in the communal dining rooms, and clearly enjoyed the food on offer. One person told us they liked the food at the service. Another person said, "I have just had a lovely cooked breakfast. I always start the day with one."

We observed the care and support given to people over lunch. We observed that people received appropriate assistance to eat. People were treated with gentleness, respect and were given opportunity to eat at their own pace. During the meal the atmosphere was calm and staff were alert to people who became distracted or dozed off and were not eating.

We saw records to confirm that people had health checks and were accompanied by staff to hospital appointments. We saw that people were regularly seen by their clinicians and when concerns were raised staff made contact with relevant healthcare professionals. For instance where people had lost weight, the staff had contacted the GP and dieticians who assisted staff to support people to maintain a healthy diet.

Good

Is the service caring?

Our findings

The people and relatives we spoke with all told us they found the staff to be very caring and friendly. We heard how staff treated people like a part of their family and would go out of their way to obtain items for individuals from the shop or bring something for them. Relatives told us they were always made to feel welcome when they visited.

One person told us, "They [staff] look after me." Another person told us, "It's better than [previous service]. I get out more." Another person said, "The staff are marvellous here. They are really very good." And another person said "The staff are lovely, they are all like angels."

Throughout the inspection we saw numerous examples of staff delivering support with care and kindness on both the units for older people and Coniston. In one example we saw two members of staff supporting someone to move using a hoist. They explained to the person what they would be doing, asked for permission and worked very slowly at the person's own pace. In another example we saw staff helping a person into their wheelchair. The person became distressed, so the member of staff helping them used appropriate touch on their hand and arm to reassure them they were safe and everything was okay. This helped the person to relax and climb into their wheelchair.

Staff clearly knew people well, and had professional but friendly relationships with them. For example, we saw a member of staff helping a person to decide what to watch on television. The member of staff knew what the person liked watching, and helped them to find a programme they enjoyed. In another example we saw a member of staff speaking with a person who was trying to decide where to spend their afternoon, encouraging them to sit in the lounge by reminding them their relatives would be visiting later and that they liked the lounge. When staff started or finished their shift we saw them walking around and saying hello or goodbye to people, with departing staff saying they would see them again soon.

Staff sat with people chatting and carrying out activities. From the interactions we observed, we could see staff knew people well. We saw staff on Coniston taking one person to the shops so they could buy a card and a gift for their relative. We could see this was important to this person.

Staff on Coniston provided people with lots of encouragement to participate in activities, eating and drinking and with personal care.

Staff treated people with respect. We saw staff knocking on people's doors and waiting for permission before entering their rooms. Where people indicated that they wanted support staff were discreet in asking how they could help and asked for permission before doing so. However, on Coniston we saw people sleeping because their bedroom doors were open. There was no information in people's care records to show that this was their preferred choice. We also saw one person using the toilet during which their dignity was exposed because the door had been left open. The night staff member explained this had occurred because they were on their own and needed to check that the other people who were up were ok, so they had just stepped out for a moment and the door must not have closed properly.

Staff told us people were supported to maintain relationships with people important to them. Staff told us they had a good rapport with people's families and they were often invited for cake and coffee. The service had received several written compliments from people and their relatives. One person wrote, 'Thank you for looking after me so well.' A relative wrote, 'The staff have always been helpful, cheerful and professional.'

People were seen to be given opportunities to make decisions and choices during the day, for example, what to have for their meal, going out or what activities to do during the day. People had care plans in place for involving them in their own care and how to do this. Care plans showed what decisions people could make for themselves.

The registered manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs.

The environment supported people's privacy and dignity. All the bedrooms we went into contained personal items that belonged to the person such as photographs and pictures and lamps. The staff took care looking after peoples' possessions as clothing was labelled and all toiletries in the bathroom were also labelled. The staff also promoted people to be as independent as possible.

Good

Is the service responsive?

Our findings

We saw that care was based on people's assessed needs and preferences. Assessments of people's support needs took place before they started using the service. Where a support need was identified a care plan was put in place to provide guidance to staff on how the person wanted to be supported. People had care plans in areas including health and safe keeping, communication, food and nutrition, personal care, mobility, social interaction, pain and skin care. Care plans set out what the person liked to do for themselves and what they would like support with. For example, one person's personal care plan provided guidance to staff on how they could help the person retain their independence with some aspects of personal care. Care plans were regularly reviewed to ensure they reflected people's current support needs. Another person was following a healthy eating plan to reduce their cholesterol. This meant staff were aware of the risk and could help the person to make suitable choices with their nutrition.

People on Coniston had one-page profiles in their care records which provided staff with important information about them. We found this information accurately reflected people's needs.

We found that although staff were knowledgeable about people's life histories and interests these were not always recorded in people's care plans. However, we saw that plans were in place to add details on people's life histories to their care plans.

We noted a number of gaps in care plan reviews and record keeping, which we highlighted during the inspection. For example, a social interaction risk plan for one person stated they could display behaviours which challenge if they became frustrated, but did not detail the behaviours which could be shown or the distraction techniques, which staff should use to lessen them. A care plan for pain stated that the person can exaggerate their pain, but the records did not provide information about this. This meant staff unfamiliar to this person would not have the all the details they needed to support them appropriately.

We found that the provider's care records led to copious and repetitive care plans being generated. A number of these overlapped so we found four plans could be in place for the same issue such as personal care or mobility. We discussed with the operational director and registered manager who agreed to look at the assessment and care plan tools. The operational manager told us that they and the new nominated individual had identified the difficulties with the care templates and that they over-complicated record keeping. As a consequence they had developed a new care record. The new templates were to be introduced in the next few weeks.

People, particularly those on Coniston unit, were involved in regular activities at the service and out in the community. Each person had their own individual activity timetable in place. Some people attended placements in the community and attended youth club. Staff on duty also took people out into the community and participated in crafts activities at the service.

Staff told us they had organised for everyone to attend the Christmas Pantomime at the local theatres and attending a local establishment for a Christmas lunch. More recently, people had participated in a 'Movie

and popcorn night.' Staff told us that people from Coniston unit provided a tuck shop service to the whole home. This meant people, staff and relatives were able to purchase drinks and snacks. Staff told us people really enjoyed this activity.

People and staff on Coniston unit worked together to carry out cleaning and laundry duties. We saw people were given choices about the activities of daily living they wished to participate in. Staff told us people enjoyed this and helped them to feel part of their community at the service.

During the morning we observed that staff working with the older people had limited opportunity to speak with people or be engaged in any form of meaningful activity. However we observed an increase in activity during the afternoon of our inspection, as the activity co-ordinators and care staff took time to facilitate some activities.

People said, "Staff always try to make sure we have a laugh and some fun during the day." And, "They are a good bunch and I like living here."

We saw that staff promptly responded to any indications that people were experiencing problems or their care needs had changed. We saw that the staff contacted healthcare professionals such as district nurses and GPs when people's health deteriorated.

People who used the service told us about the complaint procedure and stated they knew who to approach if they had concerns. Relatives also told us they knew how to raise complaints and those who had raised complaints told us the registered manager was very approachable and had resolved the issues to their satisfaction. Staff were able to explain what to do if they received a complaint but commented that they rarely received any complaints.

There was a complaints policy in place, which was advertised in the service user guide given to people when they started using the service. This set out how complaints would be investigated, including timescales for responses. Where complaints had been made we saw evidence of investigations and of outcomes being sent to the people involved. We also saw evidence of learning from complaints that had been upheld. For example, one person's relatives complained that drinks were served in their original packaging which presented a choking risk. This led to a change of policy and to drinks being decanted into jugs before they were served.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found that the registered manager failed to ensure effective arrangements were in place for overseeing the operation of the home. We found that the registered provider and registered manager had taken action to develop and enhance the way they oversaw the home to the point that the majority of issues we identified at the last inspection had been addressed. Some of the work to improve the home was still underway.

The operational manager told us that they and the new nominated individual had come into post two weeks before the inspection and were in the process of reviewing the operation of the home.

At the last inspection we found that the dependency tool remained extremely difficult to use and were unable to determine how staffing levels were calculated. The staff could not explain how they used the tool to calculate the number of staff needed for the whole home or each unit. The provider had started to take action to ensure staffing levels met people's needs and the previous operational director had been developing a new tool. However, this had not yet been agreed or implemented. We discussed the staffing levels with the new operational manager and they confirmed this aspect of the service was yet to be reviewed. We noted from the provider monthly visit report that the staffing levels did not form a part of the review being completed. In light of the issues we noted around having sufficient staff, the registered provider agreed that this would be a part of the provider monthly visit form and that it would be treated as a priority.

We also noted that since Coniston unit had opened the registered manager had delegated the oversight to senior staff working on Coniston. We found this was leading to gaps in practice; lack of team work between the units and differences in the delivery of care. The registered manager agreed they would complete the audits and review the practices in this unit.

We found that the registered manager had been in post since September 2014. The people who used the service, relatives and staff were all complimentary about them. We were told that the registered manager was approachable and easy to discuss matters with, and that they were far better than other managers who had been in post. From the information people shared with us we gained the impression that overall they thought the home met their needs.

We found that the registered manager and deputy manager understood the principles of good quality assurance and used these principles to review the service.

We saw that meetings were held with the people who used the service, relatives and staff, which provided a forum for people to share their views. We found that the registered manager ran these meetings and used a variety of techniques for encouraging people to speak up. The meeting minutes and action plans we reviewed confirmed that staff reflected on their practices and how these could be improved.

The staff had a detailed knowledge of people's needs and explained how they continually aimed to provide people with good quality care. The staff we spoke with took pride in the home they work in and described

how the registered manager constantly looked to improve the service.

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 18 HSCA RA Regulations 2014 Staffing There were insufficient staff on duty to meet the needs of all of people who used the service. Regulation 18 (1)