Magnum Care Limited

Aberry House

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Aberry House provides personal care and accommodation for up to 36 people. They specialise in providing care for people who live with dementia. On the day of the inspection 32 people were living at the home. The registered manager stated that on the day of the inspection 26 people were living with dementia.

This inspection took place on 15 and 16 February 2016. The inspection was unannounced and was carried out by two inspectors and an expert by experience.

Two registered managers were in place. 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 and associated Regulations about how the service is run. The registered manager responsible for nursing was managing the service at the time of the inspection.

We carried out an unannounced inspection of this service on 19 January 2015. Two breaches of legal requirements were found. The provider had not ensured that people were protected against the risks of unsafe care being provided by unsuitable staff, had not supported staff with adequate training to meet people's needs. After this inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We checked that the provider had followed their plan, and to confirm whether they had now met legal requirements. We found improvements in some aspects but not all issues had been properly followed up.

Since the last inspection we had received information from whistle-blowers which had stated that medication was not properly dealt with and that people receiving the
service were always dealt with in a polite manner. We followed up these issues at this inspection. We found that people were mainly respectfully dealt with and there was evidence that people had received their medicines.

On this inspection we found a breach of the Health and Social Care Act 2008 Regulated Activities Regulations 2014 with regarding to providing safe care. You can see what action we have told the provided to take on the back of the full version of this report.

People using the service and the relatives we spoke with said they thought the home was safe. Staff had been trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

People's risk assessments did not always provide staff with information of how to support people safely.

There were insufficient numbers of staff to ensure that people were protected from incidence of behaviour that challenged the service.

Staff used appropriate moving and handling techniques to safely transfer people.

People using the service and a relative told us they thought medicines were given safely and on time. Some improvements were needed to the way medicines were recorded to evidence that medicines were properly supplied to people.

The premises appeared safe with no tripping hazards observed.

Agency staff were not subject to rigorous checks to ensure they were appropriate to work with the people who used the service.

Staff had been trained to ensure they had the skills and knowledge to be able to fully meet people's needs.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives, and the service had obtained legal approval for limiting people's choices when necessary for their best interests.

People had plenty to eat and drink, everyone told us they liked the food served and people were assisted to eat when they needed help.

People's health care needs had usually been protected by referral to health care professionals when necessary.

People and relatives we spoke with told us they liked the staff and got on well with them, and we saw many examples of staff working with people in a friendly and caring way, though there were some incidents of not treating people with respect.

People and their representatives were involved in making decisions about their care, treatment and support.

Care plans were individual to the people using the service and usually covered their health and social care needs.

Activities were not always provided to meet people's needs.

People and relatives told us they would tell staff if they had any concerns and were confident they would be followed up to meet people's needs.

People, relatives, staff and professionals were satisfied with how the home was run by the registered managers.
Management carried out audits and checks to ensure the home was running properly to meet people's needs, though these needed to be more rigorous to provide comprehensive checks.

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 consistently safe.

People had not always been protected for the behaviour of others as risk assessments, action to protect their safety were not fully in place and there were insufficient staff to be able to keep people safe.

Staff recruitment checks were not always in place to protect people from unsuitable staff.

People told us said that they felt safe living in the service. Staff knew how to contact safeguarding agencies if abuse occurred.

Medication had been supplied to people as prescribed, though some people told us there were sometimes delays in receiving their medicines.

Moving and handling practices protected people safety. People's needs in relation to protecting their skin were in place.

Is the service effective?

Good

Staff were trained and supported to enable them to meet people's needs.

People's consent to care and treatment was usually sought in line with legislation and guidance.

People had plenty to eat and drink and told us they liked the food served.

Is the service caring?

Good

The service was caring

People, their relatives, and outside professionals told us that staff were friendly and caring. We observed this to be the case in the majority of interactions we saw.

Staff largely protected people's rights to dignity and privacy.

People and their relatives had been involved in planning care and decision-making.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care had not always been provided to respond to people's needs when needed. Care plans contained information for staff on how to respond to people's needs.

Staff had contacted medical services when people needed support.

People and their relatives told us that management usually listened to and acted on their comments and concerns.

Activities based on people's preferences and choices were not always readily available to them.

Is the service well-led?

Requires Improvement

This service was not consistently well led.

Staff told us the registered managers provided good support to them and had a clear vision of how friendly individual care was to be provided to meet people's needs.

Systems had been audited in order to provide a quality service though this needed to be more rigorous to ensure people safety was protected.

People and their relatives told us that management listened to and acted on their comments and concerns.

Aberry House

Detailed findings

Background to this inspection

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

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert for this inspection had experience of the care of older people with dementia and end of life care.

Before the inspection we reviewed the 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.

We also reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the service. We spoke with five people using the service. Due to communication difficulties the other people using the service were unable to share their views verbally with us, so we spent time with them and observed them being supported in communal areas and at lunch time. We also spoke with the registered manager, five relatives, two health professionals, five care workers and the cook.

We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at three people's care records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of 19 January 2015, the provider was found to have a breach of Regulation 12 relating to safe care. People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe. This was because risk assessments, designed to keep people safe, where not always followed, methods to transfer people from wheelchair to easy chair was not safely carried out, and medical services had not been alerted when people had been potentially seriously injured.

Following that inspection the provider sent us an action plan stating how they intended to address this issue. At this inspection we found there had been improvements in that people were transferred safely and medical services had been alerted when necessary. However, the provider had not fully followed their action plan with regard to ensuring that detailed risk assessments, resources and action to keep people safe were comprehensively in place, and this breach in regulation was therefore not fully met.

We looked at how risk to people was managed in the home. We looked at seven people's risk assessments. These gave staff instructions on how to care for people safely. We looked at a risk assessment for a person whose behaviour challenged people living in the home and staff. The risk assessment did not support staff on how to interact with the person to aim to ensure that the person's behaviour did not challenge other people.

There was no specific information on methods to manage this behaviour or how to de-escalate situations. Information about the person's interests and hobbies was contained in the care plan. However this information had not been used within the risk assessment to help to distract the person when these behavioural episodes occurred, or to prevent episodes occurring. We spoke with a community nurse about the management of this issue. She told us that staff had not always followed proper methods to manage this situation. For example, when the person stood up, this was an indication that they may need to use the toilet. Without staff assistance to do this, the person may have become agitated and angry. When we observed the person in the lounge standing up, staff asked him to sit down without asking whether they needed to go to the toilet. This meant there was a risk that the person could have become agitated and be a risk to staff and other people living in the home. After the inspection, the registered manager supplied us with a detailed risk assessment to manage the person's behaviour.

We looked at incident records. We found the person had initiated incidents with other people living in home and staff members. The registered manager informed us that there had been 13 such incidents in the six months previous to this inspection visit. After the inspection, the registered manager acknowledged that more staffing needed to be in place to ensure proper supervision to deal with episodes of behaviour that challenged the service.

We observed that the person started to talk on a number of occasions. We found staff did not always respond to this. On one occasion, the person asked the staff member a question but got no response. Apart from the issue of not treating the person with respect, there was a risk that the person could become agitated by being ignored. This would mean that people's safety could have been compromised.

A relative told us that her relative felt vulnerable and frightened when some people living with dementia "kick-off'. She said that although nothing untoward had happened to her relative, that she was frightened.

We found that, for the majority of the period we observed there were staff around the main lounge area to ensure that people were safe. However, this was not always the case.

Staff told us they believed there was not always sufficient staff on duty when people's needs increased on some days due to agitated behaviour or illness. One member of staff said, "It can be really difficult to care for everyone if one person's behaviour requires them to have constant supervision." Another member of staff said, "If we are short staffed because of unexpected absenteeism people have to wait."

Staff told us that agency staff usually replaced absent staff, but they told us they did not always find this helpful as the agency staff did not know the people well.

They told us they had spoken with the registered managers about the need for more staff to ensure all people's needs could be met, but they were informed that staffing levels were determined by how many vacancies were in the home. Staff informed us this method of determining staffing levels took no account of dependency levels of people in the home and the workload this generated. The registered managers disputed that staff had requested more staff and stated that there had been an increase in staff prior to the inspection and that 28 staff members were asked about this issue and they stated that extra staff were not needed to meet people's needs.

We asked the registered manager for a staffing needs assessment. We were provided with a staffing dependency assessment tool. This detailed people's personal care needs. For example, whether they needed attention to prevent pressure sores developing or whether they needed help to feed. This produced a required staffing level. However, the tool did not supply any reasons for this staffing level. We asked the registered manager who determined staffing levels. The answer given was that the provider determined levels on the basis of vacancy levels in the home. The staffing tool was not therefore used in this process.

We asked the registered manager what was needed to keep people safe. The information provided to us stated that the person in question needed one to one supervision at all times. After the inspection we received evidence that the registered manager had applied to the funding authority so that the person could receive more one to one care, and that currently the person was now on permanent one-to-one supervision. This told us that there had not been sufficient staff in place in the past to protect people's safety.

We looked at a risk assessment for a person with nutritional needs. We found that the person had been weighed regularly but had lost over six kilos in two months. However, it had taken another five days for a letter of referral to the GP had been written. This delay in action did not safely protect the person's health needs.

We checked four staff recruitment files and they all had checks in place for permanent staff. However, for agency staff, we ascertained there was no information regarding previous relevant employment information though the registered manager stated that the provider carried out DBS checks and training status checks on agency workers prior to their shift. This meant that agency staff were potentially a risk to people living in the home were employed. This was a particular concern as at the time of inspection there was a current investigation involving an agency staff member who had allegedly abused a person who lived in the home. The registered managers later provided us with a procedure that stressed that agency staff could not work in the home without previous references attesting to their character and competence.

The above issues constitute a breach of Regulation 12 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. People had not been protected from risks to their safety.

People we spoke with, and their relatives, told us they were safe living in the home. One person said, "Oh, yes, I feel safe here, I couldn't manage at home."

People had mixed views as to whether there were sufficient staff on duty to meet their needs. One person told us, "I sometimes have to wait. It depends if they are busy' I've had an… accident once and had to wait… by and large I don't have to wait long for the workers to respond to the buzzer-call." Another person told us that sometimes they had to wait up to two hours to receive their medicines.

In contrast, a relative told us she thought there were sufficient staff.

We saw a staff member providing encouragement when a person needed help standing from her seated position to walking frame, by walking beside the person to keep her safe and giving gentle support on her back and talking to her in a friendly way.

We saw that some people's care and support had been planned and delivered in a way that ensured their safety and welfare. Care records contained individual risk assessments, these were completed and regularly updated for risks, including falls, manual handling, and the risk of developing pressure ulcers. The staff we spoke with were aware of their responsibility to keep risk assessments up-to-date and to report any changes and act upon them. We saw that this had been carried out.

For example, one person was assessed as being at risk of developing a serious pressure sore. The risk assessment instructed staff to use cream for the person after supplying personal care. We saw that the community nurse had been involved to monitor this issue. This meant the person's health needs had been safely protected.

During the visit we saw no environmental hazards to put people's safety at risk from, for example, tripping and falling. Health and safety audit checks showed that water temperatures had been checked, and fire records showed that fire alarms and drills had taken place to keep people safe from fire hazards.

During our inspection we observed staff using equipment to support and move people safely in line with the instructions in care plans. We discussed with the registered manager the need to include more detail about the use of moving and handling equipment. For example, the type of equipment and the size of any sling had been recorded but the instructions did not specify which loop of the sling to use, though when we discussed this with staff on duty, they were aware of the person's needs and how to keep them safe.

Records showed that when a safeguarding incident occurred the registered managers took appropriate action. Referrals were made to the local authority and other relevant agencies and CQC was notified of these. This meant that other professionals outside the home were alerted if there were concerns about people's well-being, and the registered managers and provider did not deal with them on their own.

We spoke with staff about protecting people from abuse. Staff knew how to recognise the signs of possible abuse and their responsibility to report it. One staff member said, "I would definitely act on concerns by reporting to my team leader or a manager." Staff told us they were confident the senior staff would raise concerns correctly but were aware of what to do if they believed concerns had not been addressed. A member of staff said, "I can go straight to the local authority or to CQC." Staff also told us they would be confident to report under the whistle-blowing policy if they identified unsafe practices.

However, the whistle blowing policy we saw in people's care files did not clearly state that any staff using the policy would have protection against discrimination. This was swiftly amended by the registered manager and sent to us.

The provider's safeguarding (protecting people from abuse) policy did not clarify the roles of the local authority in safeguarding investigations. We brought this to the attention of the registered manager who promptly updated the policy by the time of the second day of the inspection.

People told us they had mostly received their medicines at the time they were supposed to get it. One relative told us that her mother's medication for pain had been properly supplied to her. A relative told us that as far as she was aware, her relative was given her medicine on time and had never been missed.

A system was in place to ensure medicines were safely managed in the home. Records showed that all the people using the service had plans in place for their medicines. Medicines were kept securely and only administered by people trained and assessed as being able to do this safely.

We looked at the medication administration records for people using the service. These showed that medicines had been given and staff had signed to confirm this. We observed some people being given their medicines. This was carried out properly and people were given fluids in order to be able to take their medicines more comfortably.

We looked at the medication system in the home. Staff have not routinely carried forward the balance of these medications so it was not possible to reconcile them accurately check that all medicines had been given. The registered manager said this would be followed up. Medication records (MAR charts) demonstrated that people were given their medication as prescribed and appropriate codes were used if a person refused or did not need their medication. Each person's medication record included information about any 'as required' (PRN) medication, including information about the medication and any possible contra-indication with their regular medication to ensure medicines were given safely. There was also some additional documentation for those people who had 'patches' applied to ensure the site was altered to ensure effective safe delivery of this medicine.

The person in charge of the medication audited the MAR charts daily so that any errors could be quickly identified. We saw that where a medication error had been made, GP advice had been sought immediately. Temperature checks for the medicine area and the fridge holding medication had been carried out and these were in line with required temperatures to make sure the effectiveness of medication was safely protected.

Good

Is the service effective?

Our findings

At our last inspection of 19 January 2015, the provider was found to have a breach of Regulation 17 relating to staff support. The provider had not ensured that staff had received comprehensive training to ensure they were able to meet people's needs. At this inspection we found that the provider had expanded the staff training programme to include issues relevant to people's care needs.

The people we spoke with said they usually received the care the support they needed. A relative told us, "I do feel the care workers here know what they are doing. Talking to the workers it seems they are always going on training." However, another relative told us that not all staff knew how to feed people, as some staff "shovelled food in", without giving people time to eat. The registered manager said this would be monitored and taken up with staff.

Staff said that the training they had received had been effective in giving them the right skills and knowledge to enable them to support people appropriately. One member of staff said, "I am offered so much training here." Another said, "We have loads of training." They, including ancillary staff, told us that they were in the process of doing, or it was planned for them to be able to gain, nationally recognised qualifications in health and social care, including National Vocational Qualifications (NVQ) and Qualifications and Credit Framework (QCF) diplomas.

We were told that some of the training was in-house, provided by staff who were considered 'a champion' for a particular training issue, such as moving and handling. They then passed this knowledge to their colleagues. A member of staff, who had not worked in care before, told us there was an induction period and no expectation from management for them to work on their own until they felt confident to do so. They said, "I definitely wouldn't do anything without asking if I didn't know what to do."

Staff told us about nursing and care and support supervision sessions. They told us there were opportunities to discuss their needs with a senior person to make sure they provided effective support people.

The staff training matrix showed that staff had training in essential issues such as dementia, epilepsy, catheter care, stoma care, diabetes, challenging behaviour and moving and handling, protecting people from abuse, moving and handling techniques, protecting people from hazardous substances, the Mental Capacity Act, health and safety, infection control and fire procedures, infection control, food hygiene, first aid, protecting people from abuse and behaviour that challenged the service. Staff are expected to complete the care certificate induction training, which covers essential personal care issues and is nationally recognised as providing comprehensive training.

We saw that staff had also undertaken training in relevant health conditions such as Parkinson's disease, stroke care, end of life care and visual and hearing impairments. This meant there was a system in place to ensure that effective care was provided to people.

For issues where training had not been provided, such as hearing impairment, the registered manager

stated that staff training would be provided to expand training for staff. This would mean that staff would be fully supported to be aware of and able to respond effectively to people's needs.

We saw that staff had been supported to be aware of their responsibilities in relation to the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and approval to ensure that any restrictions are in people's best interests, to keep them safe.

At this inspection we found evidence of comprehensive mental capacity assessments for individuals and best interest assessments. Where people were unable to make decisions themselves, the correct procedure had been followed to protect their rights under the Act. There was a form in place for assessing people's mental capacity. Deprivation of liberty (DoLs), applications had been made with proper authorisations granted to enable staff to take decisions in people's best interests.

We observed that, for the majority of situations, staff talked with people they supported and put them at ease and asked for their consent before supplying personal care. We found that staff were generally aware of their responsibilities under the Mental Capacity Act 2005. They had received training to make them aware of people's capacity to make day-to-day decisions about aspects of their care and treatment. However, there were a small number of situations where a staff member had instructed a person to sit down when they got up from their chair or were walking around, without respectfully asking them or explaining why this request had been made. Also, there was a situation whereby a staff member moved a person's chair without informing them what was going to happen with the result that the person looked startled when this happened. The registered manager said staff would be reminded as to their responsibilities in this area, as it was the expectation of the service that staff would gain people's consent when care was due to be provided to them.

We saw one care plan which indicated that although the person was deemed to have capacity to make their own decisions, their care plan had been signed by a relative rather than the person concerned, with no explanation why. The registered manager said this would be followed up.

Care plans included information that confirmed people's possible deprivation of liberty (DoLs) had been correctly considered.

All the people we spoke with said they either liked the food they were offered, or thought it was satisfactory. We saw comments in residents meeting minutes which stated there were no problems with the food. In these minutes, there was reference to people being asked as to their favourite foods so that the menu could be planned around these choices. The registered manager confirmed this had happened.

The food served appeared of sufficient portion size and was nutritious. We observed people eating in dining areas. Staff encouraged people to eat and asked some people if they needed their meals cut into bite-sized portions. One person had a specially designed plate with built-up sides, which helped her eat her meal unaided.

We found that there was a choice of main meals. People also told us they could ask for and receive an alternative if they did not want the food on offer. Everyone said that drinks were available at any time. We saw that drinks were served frequently and staff encouraged people to drink. This prevented dehydration.

Staff recorded fluid and food intakes where it was indicated so that effective care could be provided if there

had been an issue.

Two meals had been covered and left in the kitchen for people who were sleeping. However, we did note that the cook served the meals for those people in the dining room and those people in their bedrooms regardless of whether they needed support from staff. One meal was plated and left on the table for 18 minutes until a member of staff was available to take the meal to the person's bedroom and support them. When asked staff said they would reheat the meal. This was concerning as some foods cannot be heated up while still 'warm' to observe proper food hygiene. The registered manager said this issue would be followed up with staff.

The cook had a good understanding of the nutritional needs of people and the individual likes and dislikes of them. People were weighed regularly to ensure they had an adequate diet.

These were examples of effective care being provided to ensure that people's nutritional needs were promoted, though one person had not been referred swiftly to medical services when they had significant weight loss, which we have already referred to in this report.

Staff told us that the GP would be called if a person needed to be visited. Records confirmed people were supported to access other health and social care services, such as GPs, dietitians, opticians and chiropodists so that they received the care necessary for them to maintain their health and wellbeing. There was evidence of involvement of various professionals in people's care and treatment, records.

We contacted three community health professionals who told us that they and their colleagues said that staff appropriately referred issues to them, monitored people's health closely and generally followed their advice. This showed people were provided with an effective service to meet their health needs.

We saw that there were signs in place to provide a clearer environment for people living with dementia such as the colour coding of bathroom and toilet doors, having themed corridors to provide stimulation for people and having clearer signage on people's bedroom doors to produce a more user-friendly environment to provide more effective care for the people. The environment contained signs to help people living with dementia though some areas of the home lacked signs, illustrations or photographs to assist people living with dementia to locate their rooms independently. The registered manager said that this work had not been completed and other areas of the home would also have these features in the future.

Good

Is the service caring?

Our findings

People using the service that we spoke with were very positive about the staff. One person said, "The girls are lovely. Very kind and caring." Another person told us, "What I like is they ask if it's OK to do something if it needs doing before they do it, if you know what I mean – politeness and respect."

Another person commented, "I think most staff are friendly and help you. One or two could smile more."

Relatives and professionals that we spoke with also said that they had observed staff being friendly and caring.

One relative told us, ""If there is one thing I have to praise this home for is the caring aspect of the staff. They are absolutely wonderful." Another relative said, "Solid care team, totally professional…..what I like, is that they always treat my mother with dignity." Another relative told us, "I cannot ever recall the careworkers coming in this room without knocking, and my relative has been here three years."

We observed the care interactions between staff and people living in the service and found that staff were generally kind and caring.

Staff spoke with people whenever they came into the communal areas. When we spoke with staff we found they were aware of the needs of people they were providing care to.

A member of staff said, "We make sure we have patience with people and allow them to be as independent as possible." Another staff member said, "We are like one big family here."

The conversations we heard between people and staff were polite and caring. For example as staff gave people their lunch they asked permission to support them.
We observed staff treating people with dignity and respect and being discreet in relation to personal care needs. For example, when people were moved using the hoist, care was taken to ensure their clothes covered them.

We saw staff listen and respond to a person's distress, using distraction techniques over an extended time. The staff member carrying this out was consistent and caring and aware of the needs of this person.

Although a number of people had physical and communication needs, we observed that they showed affection and recognition to staff members.

We did see a small number of occasions where a person was speaking and a staff member nearby did not reply or try to engage the person in conversation. The registered manager said that he would follow this up with staff to ensure people were always respectfully responded to.

Staff told us that they respected people's privacy and dignity. They said they always knocked on people's

doors before entering their bedroom. One staff member told us, "Managers tell us to be respectful of people and I think we are. People get choices in all things like what food they want and what clothes and want to wear."

Staff described how they would preserve people's dignity and during personal care by covering them with towels.

Throughout our inspection we noted the staff we spoke with demonstrated an awareness of the likes, dislikes and care needs of the people who used the service. We observed that people who used the service had the opportunity to make choices about where they sat or what they ate. Staff described how they offered people choices about that they wore by holding up two garments if they were not able to respond orally.

A relative told us they had been involved in discussions about the care of their family member. They told us, "Staff tell me all the important things I need to know about the care." Another relative told us, "We are very much involved with my mother's care. We attend regular reviews." We also found evidence in people's care plans that either they or their representative had been involved in setting up the care plan.

All these issues showed that staff usually presented a caring and friendly manner to people and respected their rights.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff looked after their care and health needs. A person told us that the staff understand her and what her needs were, "They know which way I like to sit."

A person told us that he was not comfortable with the mattress he had because it was too hard. We informed the registered manager of this and he said he would follow this up and respond to this request.

A staff member told us, "Residents always come first and it's true. We respond to what people need."

A relative told us, "I feel we are listened to. An instance was when there was a period where pop music was being played. We suggested more age-related music and the home responded without hesitation."

We observed a staff member asking a person if they were comfortable. The staff member adjusted the person's position in her chair so that she was made more comfortable. We also saw an instance whereby one person was very concerned about a sweater he was fond of. A staff member then went to get the laundry worker to speak with him. She told him that it was being washed at the moment but she would find out when it was ready. The person was happy with this response.

We looked at care plans for seven people using the service. People's needs had been assessed prior to them moving to the service. The information gained from these assessments was used to develop care plans to aim to ensure that people received the care and support they needed. We saw that each person had a keyworker, which is a member of staff who is specifically allocated to a person to ensure their needs are met. When we spoke with staff about people's needs, they were familiar with them and were able to provide detailed information about people's likes and dislikes.

Care plans were in place and were reviewed at least every month. More specific information was sometimes needed to ensure proper care. For example, there was no information as to which loop of a sling was needed to ensure a comfortable moving and handling manoeuvre. We also noticed that the weight of the person did not correspond to the settings on the pump of a pressure relieving mattress. The registered manager agreed with this and later told us he had taken action to adjust the setting so that it provided it effective treatment.

We saw that turn charts recording action needed to protect people's skin were completed by staff to ensure appropriate care was provided. They had been completed in line with the instructions in the care files. Care files included detailed information for staff about a person's condition. For example, there was information about strokes and how to recognise when they might be taking place and when to respond to this need.

Where people could not communicate effectively because of their physical condition, information about non-verbal communication had been recorded so that care responsive of their needs could be provided to them.

We saw a notice from the registered manager in November 2015 which stated that staff could not provide

person centred care if they did not know the contents of care plans. Staff told us that registered managers had asked them to read care plans. However, for the plans we saw, a majority of staff had not signed to indicate they had read them. The registered manager said this would be followed up with staff again to ensure this was carried out so that staff were aware of how to respond to people's individual needs.

We were told that been memory displays of past events were displayed and changed at regular intervals. We saw an example of this, as the day before the inspection was Valentine's Day. There were hanging heart chocolates, red roses in vases, love bears displayed and chocolates had been given to people by the provider. People told us that they enjoyed this activity.

Activity information was displayed in the corridor. This included a variety of different activities. However, a relative told us, "What you see on the board bears little resemblance to what actually happens. Sometimes it happens, sometimes it doesn't."

Staff members told us there was a need for a dedicated activity coordinator. A staff member said, "I'm not saying we shouldn't be doing it, it is an aspect of care but when you are pushed job-wise and time-wise between playing cards with a resident and someone wanting to go to the toilet, the toilet wins all the time. We are pushed (for time) quite often." Two other staff also said an activity coordinator was needed to ensure that people received activities because the current arrangement meant staff could be called away at any time to provide care, which interrupted the activity. Staff told us that the only complaints they heard from people was a lack of activities. In people's activities logs, we saw that the only activities people received in four consecutive days had been recorded as the TV and radio and a small number of people had a reminiscence session.

We saw that a hairdresser and chiropodist came regularly to provide a service to people.

When we toured the home with the registered manager, we went into two people's bedrooms where age appropriate music was not played on the radio. A relative told us that when visiting, this music had been turned to a radio station that was not to the taste of her relative. We also saw that the TV in a lounge with people living with dementia sitting in it was showing a confrontational chat program with people arguing loudly on it, which could have caused agitation. However, there was no one was watching it. The registered manager said staff had been reminded to ensure appropriate music and TV stations were put on by staff and he would remind them again to do this. At lunchtime, we noted this had been rectified with age related music played.

There was little evidence that people's choices of activities as shown in their care plans had been provided. Choices had been considered in the activities provided.

We saw evidence of a review in 2015, in the action plan from the resident and relative survey. This specified outings that would take place and people confirmed that this had been the case. There was also information about everyday activities that people could carry out such as sweeping, table cleaning and napkin folding and we saw the weekly entertainment schedule and other activities in the log book. There was a reference in a relative's meeting in December 2015 where relatives had noted a lack of daily activities. The registered manager said this issue would be reviewed and improved and later sent us information that which stated they had appointed an activities champion to provide activities for people living in the service. This should mean people had activities responding to their needs.

Most relatives we spoke with said they had never had to make a complaint. They said they felt confident that they could approach both registered managers as they thought they were very approachable, though one

relative said that staff did not always feedback what action had been taken about their concern. The registered manager said this would be followed up to ensure this always happened.

We looked at the complaints book which contained a number of complaints. Proper investigations had been carried out on the issues concerned and action was identified when needed. This provided evidence that the service responded to formal complaints..

The provider's complaints procedure set out the proper role of the local authority in undertaking complaints investigations if the person was not satisfied with the action taken by the provider.

We looked at care records which showed that medical agencies had been appropriately referred to when needed. The health professionals we spoke with confirmed that the staff contacted them appropriately to refer people for treatment. We saw records of accidents. We found staff had referred people to medical services when they had an accident. People's needs had therefore been responded to.

Requires Improvement

Is the service well-led?

Our findings

When we asked a person how they rated the home, they said, "Highly!" A relative told us, "I feel the staff are very professional in a very informal way. They have the interest of the residents at their heart." Another relative said she would give the home nine out of ten and said she struggled to find any faults with it.

People and relatives we spoke with told us that the registered managers were approachable. One person said, "If I mention anything to them, they will do something about it." There was praise given to the registered managers from residents, relatives and staff. All said they were very approachable.

A relative told us, "I think it is truly well-led. You can tell by the way the staff react….it sort of cascades down….. a really nice approach."

A staff member told us, "(registered manager's name) is very approachable. I can go to her for anything. She listens. In fact they both are good." She said that the registered managers resolved any conflict among staff by addressing issues quickly.

Another staff member said, "Residents always come first and …. we respond to what people need."

Staff told us they could approach the registered managers about any concerns they had. One staff said, "I could go to (registered manager's name) with anything." Another staff member said, "We know we can go to the managers for anything. They are always available to listen to what we say and try to support us."

Staff members we spoke with told us that the registered managers led by example and always expected people to be treated with dignity and respect. They told us
they would recommend the home to a relative of theirs because they thought the home was well run and the interests of people were always put first.

We saw that residents meetings had taken place. These included relevant issues such as gaining people's views of the service about issues such as activities, food, staff training and facilities.

Staff said that essential information about people's needs had always been communicated to them by way of daily handovers so that they could provide appropriate care that met people's needs. These are examples of a well led service.

Staff were supported through individual supervision and staff meetings. Records showed that issues about staff practice were discussed in staff meetings and any necessary remedial action identified with staff. Staff supervision records evidenced that supervisions covered relevant issues such as training and care issues. This meant that staff were supported to discuss their competence and identify their learning needs.

We saw that people had been asked their opinions of the service in the past year by way of completing satisfaction surveys. We noted that everyone was satisfied with the running of the service. Relatives and staff

had also been asked for their views in 2015 by way of completing satisfaction surveys. Again, everyone expressed their general satisfaction with the running of the service.

This showed that people living in the service and other relevant people were consulted about the running of the service to make sure that people's needs had been met.

The registered manager had implemented a system to ensure quality was monitored and assessed within the service. We looked at a number of quality assurance audits. We saw that the registered managers had introduced audit procedures on a large number of relevant issues such as care planning, fire checks, maintenance checks, protecting people skin from pressure sores, medicines administration, weight charts, food hygiene infection control and room audits.

However, audits had not identified that agency staff needed to be more thoroughly checked before they began working in the service. Analysis of incidents did not include the necessity to have more supervision of people with behaviour that challenged the service. By having more rigorous quality assurance systems in place, this would comprehensively protect the safety of people living in 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not been protected from risks to their safety.