Maria Mallaband Limited

Bridge House 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?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on the 15 April and 20 April 2015 and was unannounced on both days.

Bridge House Care Home is owned by the Maria Mallaband Care Group. The service is registered to provide accommodation with personal care for up to 30 people. At the time of our inspection there were 22 people living at the service, some of whom are living with dementia. The majority of people were mobile and able live their lives independently. The accommodation is over two floors that are accessible by stairs and a passenger lift. There is an annexe that can accommodate three people who are very independent.

At the time of our visit a new manager was in post and had begun the process of submitting an application to register with the Care Quality Commission (CQC). The previous registered manager had been transferred to another service owned by the provider and was in the process of de-registering as the manager for Bridge House Care Home. A registered manager is a person who

Summary of findings

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 were at risk because there were inconsistencies in the systems and arrangements to protect people from the spread of infection. Appropriate standards of cleanliness were not being maintained. Infection control policies and procedures were in place; however, these had not always been followed. There were malodours in four bedrooms and a communal bathroom. The bedding and mattresses in two bedrooms were stained.

During this inspection we found that the provider had not always recruited staff safely. This put people at risk of receiving care from staff who may not be suitable to work with people in a caring environment. Documents required to ensure people are safe to work with vulnerable people had not been obtained in respect of prospective employees.

People could be at risk because of how staff were deployed. Some people and relatives remarked on how busy the staff were and told us staff really tried to do their best in often challenging situations. Some people told us they had to wait for a member of staff to be available if they wanted to have a bath or a shower, others told us they did not have to wait. Staff were satisfied that there were enough staff on duty to meet the needs of people. We have made a recommendation about this in our report.

The environment did not support the independence of people who had dementia as parts were poorly lit and there was a lack of signage in the key areas of the building including people's bedroom doors.

People told us they felt safe living at the service. Staff had received training in relation to safeguarding adults and were able to describe the types of abuse and processes to be followed when reporting suspect or actual abuse.

Staff had received training and regular supervisions that helped them to perform their duties. They told us that they had completed induction prior to commencing their duties at the service.

Medicines were administered safely by staff and systems were in place for the recording and storage of medicines. People received their medicines as prescribed by their GP

People we spoke with were positive about the care they received and their consent was sought. People were positive about the caring nature of the home and all the people we spoke to consistently said that they would be happy to recommend the home. People told us that staff treated them with respect and attended to their personal care needs in private.

People's care and health needs were assessed and they were able access to all healthcare professionals as and when they required.

People's nutritional needs had been assessed and people were supported by staff to eat and drink as and when required. Not all the people we spoke with were complimentary about the way the food was always cooked. Some people told us that the meals were a set menu and the vegetables could do with more cooking time. They were not aware of the choices available to them. The menus we looked at provided a choice of meals and people were asked each morning to choose their preferred meal.

Documentation that enabled staff to support people and to record the care and treatment they had received was up to date and regularly reviewed. People had signed their care plans that signified they had been involved in writing and reviewing their plans of care. Peoples' preferences, likes and dislikes were recorded and staff were knowledgeable about the care needs of people.

People and relatives told us they thought the service was well run and they were able to have open discussions with staff. People told us they were able to raise concerns and make complaints if they needed to.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not fully safe.

People were at risk of receiving care from staff who had not been appropriately vetted.

The staff team were qualified, skilled and experienced to support people's care needs. However, people could be at risk because of how staff were deployed.

People felt safe living at the service. Staff were aware of what abuse was and the processes to be followed when abuse or suspected abuse had been identified.

Medicines were administered and stored safely.

Is the service effective?

Requires improvement

The service was not fully effective.

People were supported to have enough to eat and drink throughout the day and night. There were arrangements in place to identify and support people who were nutritionally at risk. People were offered a choice of freshly cooked meals but had not been included in the planning of the menus. Not all the people were satisfied with how the food was cooked.

The environment did not support the independence of people who had dementia.

Staff had received training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and knew their roles and responsibilities.

Staff had received training that enabled them to support people.

People told us that they could access all health care professionals when they needed to and staff supported them to do this.

Is the service caring?

Good

The service was caring.

People told us they felt they were looked after by caring staff.

People's needs were assessed and care and support was planned and delivered in line with people's individual care plan.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not fully responsive.

Activities had not been embedded at the service.

People received care and treatment that was responsive to their needs.

People had risk assessments based on their individual care and support needs. Care plans were detailed and regularly reviewed to ensure people's assessed needs continued to be met.

People and relatives told us they knew how to make a complaint and were confident that concerns raised would be dealt with promptly.

Is the service well-led?

Requires improvement 

The service was not fully well-led.

Audit checks for the cleaning of the service were not effective and had not been checked or signed by a domestic supervisor.

People felt that this was a well-run service with a culture of being able to speak up about any issues or concerns and that all the staff were approachable.

Staff felt they were supported by the manager. There was open communication within the staff team and staff felt comfortable discussing any concerns.

Bridge House 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 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.

This inspection took place on 15 April and 20 April 2015 and was unannounced on both days.

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.

We did not ask for provider information record (PIR) because we visited due to concerns raised.

We observed people in the communal areas and staff interaction with people. We spoke with 16 people who live at the service, four relatives and one visitor, three members of staff, the manager and the quality assurance manager. We read care plans for three people, audits undertaken by the provider and manager, staff training records, supervisions and appraisal records, four staff recruitment files, staff meeting minutes and a selection of policies and procedures.

The previous inspection carried out on 10 March 2014 found the service to meet the standards inspected.

Requires improvement

Is the service safe?

Our findings

People living at the service were not safe because the systems and arrangements in place to protect people from the spread of infection were not effective. We noted that there was an unpleasant smell coming from one bedroom that was not currently occupied. We were informed that this bedroom had been cleaned, however, the armchair emitted an unpleasant smell and the toilet seat had not been cleaned. We noted strong smells in three other bedrooms and a chair in one of the lounges. A communal bathroom had a dirty toilet under the seat although staff told us it had been cleaned. We noted in one occupied and one empty bedroom that the bedding and mattresses were stained. We brought this to the attention of the manager who addressed this issue immediately.

We saw in the dining room and a bedroom that cobwebs were hanging from the walls and corners of the ceiling. Cleaning schedules had indicated that these rooms had been cleaned. The manager could not offer an explanation as to why these had been missed but immediately asked a member of staff to attend to the issues identified.

The laundry room was dirty. There was a large rip on the floor covering therefore rendering the floor not sealed and had dirt which could harbour germs and bacteria. The sinks and work surfaces were not clean. There was not a separate clean and dirty area in the laundry to reduce the risk of cross infection from dirty clothes contaminating clean clothes. We noted clean clothes were hung on a rail above the dirty laundry that was kept on the floor in baskets. This posed a risk of clean clothes becoming contaminated.

On the second day of our visit we noted that efforts had been made to clean the areas previously identified. We saw that new beds had been ordered by the manager and new bedding had been delivered. This included duvets, duvet covers, sheets, pillows and covers.

Staff had attended training in relation to infection control. Staff were aware of the measures to prevent the spread of infection. For example, they were able to explain why and when protective clothing should be worn and the use of colour coded mops for different floor types.

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

Staff told us that they thought their recruitment process was fair, however, one person told us that they could not recall completing an application form. Staff stated that they had to provide the names of referees, proof of their identification and had a Criminal Record Bureau (CRB) check, now known as a Disclosure and Barring Service (DBS) check undertaken. These checks are undertaken to ensure staff are suitable to work with vulnerable people. The provider had a recruitment policy that should be followed when recruiting new staff to work at the service. This document was dated March 2015; however, this stated that potential employees would be asked to give specific reasons for gaps in employment for the last ten years instead of for any gaps in their full employment history. We sampled staff recruitment files. We noted that the application forms used had not requested a full employment history as required, there were gaps in employment that had not been explored, in two files there was only one reference. Two files did not have any proof of identity. This meant that adequate checks were not properly conducted to ensure that people were cared for by appropriately vetted staff.

This was in breach of Regulation 19 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people remarked on how busy the staff were and told us staff really tried to do their best in often challenging situations. Relatives told us that the service needed more staff as they are always running around. One relative told us, “When I arrive at the door I always expect it to take them a while to answer. There is just a sense of not enough staff and not enough time.”

Some people felt they could not choose the time to have a bath, as they had to wait for a member of staff to be available, however, other people stated they could bath or shower when they wished to. We discussed this with the manager who told us that people could bath and shower when they chose and this would be reiterated in the next residents’ meeting.

Staff told us that they felt there were enough staff on duty to meet the needs of people. They told us that there was a minimum of three care staff on duty during the morning and afternoon shift, plus two domestic staff, an activity coordinator who had recently taken up their post and a cook.

Requires improvement

Is the service safe?

We looked at the staff duty rotas covering a six week period. The manager told us that she was supernumerary to the duty rota. The rotas we looked at were not very clear. For example, one weeks' rota had stated it was for the week commencing Monday 6 March 2015, this week was actually Monday 9 March 2015. On 17 and 19 April 2015 there were only two members of staff on duty for the morning and afternoon shifts. The third member of staff was an agency worker and was signified by an "X," but the hours they worked had not been recorded.

We observed during our inspection that there were three staff on duty that included a senior member of staff. The manager told us that they had undertaken an assessment of the needs of people to ascertain the staff ratio for the service every month and that was how the numbers of staff had been determined. However, concerns were raised by people and relatives in relation to staff numbers. We observed that at 2.45pm one person, who was in their bedroom, still had lunch in front of them and was not eating. A member of staff did go to encourage the person to eat but clearly had to go and attend to others so was unable to stay. During both our visits to the service we observed that staff were very busy attending to people. People told us that they never had to wait when they used their call bells as staff always responded quickly. This meant that it was difficult to ascertain if there were enough staff on duty at all times to attend to the assessed needs of people.

Whilst there were sufficient numbers of staff on duty, we recommend that he provider reviews how staff are deployed to ensure people's needs are met.

People who live at Bridge House told us that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. This included relatives who felt they could raise issues without feeling uncomfortable. Three people sitting together all agreed with one saying, "We are happy and safe here, nothing to grumble about." Another person told us, "I would definitely say if I wasn't happy. I was living abroad and came back and I'm glad I did."

Staff told us they had received training in relation to safeguarding people from abuse and had read and understood the safeguarding policy that was produced by the provider and provided guidance to staff on the action to be taken and described the different types of abuse in detail. Staff were able to describe the types of abuse and the process they would follow should they suspect or witness any form of abuse. They were aware of the external agencies to be contacted and which external body took the lead to investigate concerns relating to abuse.

People's care plans we looked at contained individual risk assessments in which risks to people's safety were identified such as falls, mobility, pain, and nutrition and skin integrity. Guidance about any action staff needed to take to ensure people were protected from harm was included in the risk assessment. Records showed that where people's needs changed, staff completed appropriate risk assessments and recorded any further action required. For example, Nutrition assessment was completed along with a malnutrition screening tool to identified any risks. The required action was monitor the dietary intake for at least 3 days.

People also told us that medicine was administered on time and that supplies didn't run out. One person told us, "They've always got my pills and keep them topped up." We looked at medicine management to check if safe systems were in place. The manager and staff told us only senior staff who had received the appropriate training administered medicines.

We looked at the medicine administration records (MAR) sheets. These recorded the quantities of medicines given. Each person had a MAR sheet that included a colour photograph of the person so staff could clearly identify the person to help prevent errors.

We observed a member of staff had administered medicine and signed the MAR sheets after the medicine had been taken. We noted that MAR records were used appropriately and there were no gaps or omissions in relation to people receiving their medicines. We saw the staff member undertaking the medicine round explaining to people what their medicines were for and how their medicines helped them.

We saw the provider had written individual PRN [medicines to be taken as required] protocols for each medicine that people would take. These provided information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of.

All medicines were stored securely so they could not be accessed by unauthorised people. Records of medicines received and returned were appropriately recorded.

Requires improvement

Is the service safe?

The service had a business contingency plan that detailed the actions to be taken to minimise the effects on people and the business in the event of an emergency. Fire evacuation procedures had been written for people and staff were knowledgeable about the evacuation procedures.

Requires improvement

Is the service effective?

Our findings

We noted that the environment did not support the independence of people who had dementia. For example, there were steps along corridors, some areas of poor lighting, lack of clear signage including people's bedrooms. The manager told us they had identified these shortfalls and they had been included in the planned redecoration of the service. The quality assurance manager told us that the provider had recently introduced a dementia strategy. This was because they were aware of the changing needs of people living at the service. This included two days training for staff on dementia, and included how to support people's emotions and strategies for dealing with behaviours that challenged.

Menus included a choice of meal each day, however, it was not in pictorial or other format to support the independence of people with varying needs living at the service. No one was able to say what was for lunch today prior to the meal. On asking people at the lunch table how their meal was, some said it was nice, whilst others particularly showed us that their vegetables were hard. We spoke with the manager about the concerns about the meals that were raised during discussions with people and relatives. We were informed that the chef was on leave but was due to return in June 2015 and they would monitor the situation until then. Whilst the chef was on leave, the cooking duties were being carried out by care staff at the service who had attended food hygiene training. We were told, and we saw in the quality assurance reports, that issues in relation to food had been identified during the quality monitoring of the service in February this year and action was taken by the provider to resolve this. The food we saw looked appetising and plentiful and people had made choices of their meals. Overall comments about the food was good but not to everyone's liking. The manager told us they would continue to monitor the situation.

We saw staff discuss the menu choices with people and their choice was recorded and passed on to the kitchen staff. We saw that one person did not want what was on offer and they asked for an alternative meal that was provided to them. Drinks and snacks were available for people . We noticed that there was no evidence that people had been included in the planning of the menus. People did not tell us that they had been included with the planning of the menus.

Care plans we looked at included nutritional risk assessments. Referrals had been made to dietary and nutritional specialists when a concern had been identified in relation their nutritional and hydration needs. For example, one person had scored high on a malnutrition assessment tool. We saw that a referral had been made to the GP who made a referral to a dietician. Food and fluid chart had been implemented and weekly weights had been recorded. These meant risks to people's nutrition and hydration needs were monitored and addressed.

People told us that staff were competent and skilled at their roles. People were complimentary about the staff and how they looked after them. One person told us, "They know what to do, yes they are very good. When I've been ill they supported and showered me even at 2 o'clock in the morning and it's been no trouble to them." Another person told us, "If they have any doubts about anything they always go and check things out."

Staff told us that they had received induction training when they commenced working at the home and they had regular updated mandatory training. Other training attended by staff included dementia, Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and Control of Substances Hazardous to Health (COSHH). We saw evidence of training certificates in the staff records we looked at. The manager also provided us with a training programme that showed the training staff had received. Staff were able to talk about what they had learnt from their training. For example, medicines, how they check to ensure they are giving the right medicine to the right person, dating when liquids had been opened and the need to explain to people what their medicine is for.

Staff told us they had regular supervisions and had in the past had appraisals where they discussed their roles and identified any training needs. We saw records that confirmed this. We noted staff had not received annual appraisals since 2013. The manager told us they were aware of this and as they were new in post, they were undertaking supervisions with all staff and would then commence appraisals. Staff told us they felt supported by the new manager and the communication between the team is good. On the day of our visit some staff were attending training on dementia. We saw staff working in an independent way with people. This meant that staff received training that helped them in their role to care for and attend to people's assessed needs.

Requires improvement

Is the service effective?

The manager told us that staff had received training in relation to the MCA and DoLS. These specify the actions to be taken to ensure that people who cannot make decisions for themselves are protected. The DoLS provide a legal framework to restrict a person's liberty in specific circumstances.

Staff were able to clarify what we had been told about the training in relation to the MCA and DoLS. They were knowledgeable and had a good understanding of when an application to deprive someone of their liberty was required to be made. They told us that people living at the service could make every day decisions. For example, they could choose the clothes they wished to wear and where they would like to eat their meals. . We noted all external doors had key pads and people were aware of the codes. We saw people freely accessing the gardens during our visits.

Staff told us they would gain consent from people before they assisted them. During our observations we saw that staff asked for people's permission before they did anything. For example, people were asked if they had finished their lunch or would like any more before their plates were taken away at lunch time. We saw staff knocked on people's doors, even when they were open, and waited for permission before they went into people's rooms.

We saw that a mental capacity assessment had been undertaken for one person who was living with dementia. We also saw, where required, that 'do not attempt to resuscitate' (DNARCPR) forms were in place. These had been signed by the GP, family members and the person they related to. These documents had been completed in line with the MCA.

People told us that they had access to all the health care professionals they required. One person told us that they felt that medical attention would be sought when required. They said, "I've heard an ambulance come in the middle of the night." One relative told us, "Yes, we had a scare when my X was being given her medicine." They told us their family member fell unconscious. They rang the GP and contacted us immediately. The GP came promptly and my relative just suddenly started speaking again. Care plans included information about health care professionals people had seen, including for example, the GP, chiropodist and community nurses. This showed us that staff at the service ensured that people's health care needs were responded to.

Good

Is the service caring?

Our findings

People and relatives we spoke to were very positive about the care they received and how caring the staff were at the service. People told us that staff treated them in a respectful manner and they were always attentive to their needs. One person told us, "They are kindness itself, nothing is too much trouble." Another person told us, "The staff are lovely they couldn't be nicer." This was echoed by relatives who told us, "The staff really do care and have good relationships with X. She has recently been in hospital and they were genuinely looking forward to her coming back." During our visits we saw staff interacting with people in a polite and kind manner and addressing people by their preferred names.

Staff we spoke with were knowledgeable about the needs of people they looked after. For example, they knew the person's family history, their current personal care needs, how to attend to them and their likes and dislikes.

People told us they were able to make decisions for themselves. They told us they could stay in their bedrooms if they wished to, could choose where to have their meals and what time they wanted to get up.

The manager and staff told us that people were involved in their care plans, but when this was not possible, then their relatives would be involved and would sign their care plans to signify their involvement. The care plans we looked had been signed by people. This meant that people and their relatives were involved in the development of their care plans.

During our visits we saw people looked comfortable and well presented and were having conversations with other people, visitors and staff. We saw people had access to all communal parts of the home and to the gardens. This showed us that people were cared for by staff and supported to be as independent as they were able to be.

The service had a Dignity and Privacy policy that provided guidance to staff in relation to standards for dignity and care. There was also information from external organisations, for example, Skills for Care and the Social Care Institute for Excellence. This provided up to date information about training and legislation to the service about caring for people in residential care homes. We observed staff treating people in a respectful manner, they were calling people by their preferred names and attending to the person care needs in the privacy of people's bedrooms.

Staff told us how they supported and respected people's privacy and dignity. We observed staff knocking on bedroom doors and waiting for a response and attending to the personal care needs of people in the privacy of their bedrooms with the doors closed. Staff told us they supported people be as independent as they were able to be. We observed a carer assisting a person to the dining room. The carer was calm and didn't rush the person giving them lots of time to get their balance and had a guiding hand gently placed on their back. "Take your time X, well done, are you okay. Are you not too hot in that cardigan?"

People told us that they felt their independence was maintained. One person told us, "I go to the kitchen and make myself a hot drink whenever I want one." Another person told us, "I absolutely choose what I'm doing, in fact I'm off out to lunch today. They're there if you want them but I tend to get on with things myself." A third person said, "I walk up to the village and use my bus pass"

A relative told us, "X sometimes needs help with their meal but sometimes doesn't so the staff help when needed."

To promote people's choice and independence, we saw information about advocacy services was available in leaflet form in the entrance hall to the service for anyone who required it. An advocate is an independent person who will support a person with making decisions. People we spoke with told us the did not need an advocate.

Requires improvement

Is the service responsive?

Our findings

Each person had a care plan in place that provided information about how they liked their needs to be supported by staff. Their care needs had been assessed prior to using the service and we saw that monthly evaluations had taken place. Some people told us they had been involved in their care plans. Staff maintained daily records that recorded how individual's needs had been met and any changes implemented. We noted that general risk assessments had been completed, but they were not personalised. For example, X is aware of the risks and understands the actions that had to be taken, however, the risk assessment had not been written in a person centred way as from X's point of view. This meant that we could not ascertain how much involvement people had with their care plans.

Care plans included information entitled "Me and my Life." This recorded the history and personal choices of the individual person. It also provided information about people's likes, dislikes and their spiritual and cultural needs. People told us that church leaders visited the home and people sometimes had individual meetings in their bedrooms where people preferred privacy. One person told us, "They come to my room and we pray in there together."

We saw information about how to meet the needs of one person who had dementia in their care plan. For example, this included what to do if the person was in low mood. It identified the time of day when this was more likely to happen and guidance and strategies on how reassure and support the person. This meant that information and training was provided to staff so they could meet the needs of people.

Staff were responsive to people's needs. During our visit a person had a fall in an empty bedroom. The call bell was sounded and staff immediately responded and summoned an ambulance. We saw staff had stayed with the person, reassuring them and making sure they were supported until the paramedics arrived. First aid was provided to the person by staff.

Another person said, "I just want to tell you about the marvellous treatment I have just had. Just after I had spoken to you this morning I went to get my visitors a cup of tea and I fell. Staff got me up quickly and I've been out to lunch. I'm okay I'll probably have a few bruises but I'm fine."

We observed staff talking to people and asking how they were. For example, we saw a member of staff ask one person how they were, "X are you OK, and you seem to be in pain?" The person responded and told the staff that they had a pain in their leg but had been given painkillers for it.

We noted that one bedroom had the flooring changed at the request of a person and their relative as it was not suitable to their needs. In one person's care plan they had asked to move bedrooms because they liked the view of the garden from the bedroom window and this request had been carried out.

On the first day of our visit we did not see any planned activities taking place. One person told us, "There is not a lot to do, sometimes you just wander around or you might get to play chess or get to know people." Several other people spoke of singing activities, scrabble, board games, and Christmas and garden parties. Some people were taken out regularly by family members.

The service had employed a full time activities coordinator who had only recently commenced their role. The activity coordinator was planning morning and afternoon activities a month ahead so people would know in advance what would be on offer. Daily activity lists had been produced and were displayed on the dining room door and in the communal areas. We also saw these in individual bedrooms. One to one activities were being planned for people who preferred to stay in their bedrooms.

Throughout our visits we saw relatives visiting, spending time with their family member and taking them out for the day. The activity coordinator told us, "Those who have dementia are happy to watch activities." Some people need a lot of help and I talk to the relatives and find out what they used to like. They told us that they also provided activities to people with dementia on a one to one basis and records of these were maintained in individual care plans. For example, one person does not want to come out of their room, so the activity coordinator goes in to their room and has a chat with them. Another person doesn't want to join in but they are always in the lounge watching. On the second day of our visit we saw activities taking place. People were playing board games and sitting out in the garden. Some people had chosen to watch television in the lounge and they had the television control so they could choose to watch what they wanted.

Requires improvement

Is the service responsive?

The activity coordinator told us that they find out what activities people like, they get their history and try and do some things that they like. They told us that activities are planned for twice a day, but they also spend one to one time with people who don't want to do it or are in bed. Records of activities are recorded daily and include the type of activity, who attended and feedback. This information is placed in the care plan. For example one person doesn't want to come out of their room, so the activity coordinator go in and have a chat with her. Another person doesn't want to join in but they are always in the lounge. We saw people sitting in the lounge areas playing scrabble, some were quite enthusiastic about this game. Some people were enjoying the good weather and sat out in the garden.

Although the new activity coordinator was arranging activities, during our first day we did not see any activities taking place. The activity lists provided to us showed that there was only one activity offered each day as opposed to two that we were told.

People told us that they knew who to make a complaint to and any concerns they have had were sorted out by the manager. They told us that they felt there was a culture of being able to speak up about any issues or concerns and that all the staff were approachable. One person told us, "Oh yes if I have a moan about anything they sort it out straight away. Even something like a narrow pillow slip that really annoys me, I just tell the night carers and they change them." One relative told us, "Where there have been issues we have been happy with how things have been dealt with."

The service had a complaints policy that was reviewed in March 2015. This provided information on the expected time scales for responses and for the complaint to be fully investigated. It also included the contact details of the local government ombudsman, the regional director of the service and the duty social worker for the local authority. This was displayed in the entrance to the home and in the service user guide. We saw that the provider maintained a record of complaints that included how they responded and any feedback to the complainant. The manager told us that people with dementia had relatives who would speak up for them and staff would always report any concerns they noticed on behalf of people to the manager.

Requires improvement

Is the service well-led?

Our findings

We saw that internal audits had taken place, including for example, medicines, care plans and health and safety. This meant that the manager ensured people's assessed needs were being managed and actions were taken when issues had been identified. For example, the flooring in one of the bathrooms had been identified as a hazard and was changed as a result. However, we found that the audit checks for the cleaning of the service had not been checked or signed by a domestic supervisor. This meant that there were ineffective systems in place for the monitoring of the spread of infection and control that could put people at risk.

People felt that this was a well-run home with a culture of being able to speak up about any issues or concerns and that all the staff were approachable. One person told us, "It's well organised I've not found another to beat it." Another person said, "I know the governor well here and can have a chat when I want."

Relatives said that they were always made to feel welcome when they visited and that they could visit at any time. They also said the atmosphere seemed to be calm and relaxed. One relative told us, "There isn't a high turnover of carers and a core staff have been here a long time so they know X well."

People told us that there was a suggestions box and relatives said that there had been a meeting on the arrival of the new manager. One relative told us, "It was really useful and I did suggest that it would be a good idea to have them. I don't know if they will."

People said that there had been residents' meetings in the past but not for a while due to the change in management staff. We discussed this with the manager who told us that a residents' meeting had been planned for the first week of May when topics such as meals, supper times and activities would be discussed.

The visions and values of the service were displayed in the entrance hall and the aims of the service were included in the service user guide that was provided to people. They included supporting and maintaining the dignity of people, providing a safe, warm clean and friendly environment and the continued improvement and development of staff. Staff were seen to provide support to people in a way which met the values of the service. For example, saw staff supporting people in a caring way, attending to personal care needs in private and addressing people by their preferred names. However, we did identify issues relating to the environment that included the laundry room, cleanliness of identified bedrooms and one communal bathroom. .

There was a management structure in the home which provided clear lines of responsibility and accountability. This included a manager, deputy manager and senior carers and care staff. Job descriptions were available in staff files we looked at. The current manager commenced their role in February 2015 and is currently in the process of submitting an application to register with the Care Quality Commission.

Staff told us they were able to have open discussions with the new manager. They said that there was a good staff team at the service and they really get on well together. They felt that the manager and deputy manager were very approachable and supportive. Staff told us they had handover meetings every day and six weekly staff meetings. We saw records of staff meetings that had taken place. Topics discussed included medicines, care plans, staffing, training and supervision.

There were quality assurance systems in place to monitor care and plan ongoing improvements. Quality assurance checks were undertaken on a monthly basis by the quality assurance manager. We saw samples of these during our visit. We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example, it had been identified that there was a lack of activities for people. The action taken was to put an activity programme in place and the provider employed an activity coordinator to plan and deliver activities. Short falls in relation to staff training had been identified and action taken. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The service maintained records of accidents and incidents. The manager told us that monthly analysis of these was undertaken to identify any patterns. The manager stated, and this was confirmed by staff, that accidents and incidents were discussed during staff meetings so lessons could be learnt from these, therefore lessening the chance of repeat incidents.

We saw that annual surveys were sent to people and their relatives and reports were published and discussed during resident/relative and staff meetings. The last survey was

Requires improvement

Is the service well-led?

undertaken in July 2014. A summary of the finding and an action plan to address issues had been produced and completed. For example, one issue was that people and relatives had not been asked to identify useful information about people's past. Life history books had now been put in place that collated this information.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Care and treatment was not provided in a safe way for service users. The provider had not assessed the risk of, and prevented, detected and controlled the spread of, infections, including those that are health care related. Regulation 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Information must be available in relation to each person employed as specified in schedule 3 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.