

Maria Mallaband (6) Limited

Clarendon Court Care Home

Inspection report

Beechwood Close
Stapeley
Nantwich
Cheshire
CW5 7FY

Tel: 01270621500

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15 June 2018

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 13 and 15 June 2018. The first day of the inspection was unannounced. This meant that the provider and staff did not know we were coming. We last inspected the service in June 2016 and at that time identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach was related to safeguarding.

We took action by requesting the provider send us an action plan stating how and when they would achieve compliance. During this inspection we found that the service was no longer in breach of this regulation. Some action had been taken to ensure that safeguarding referrals were reported appropriately. However, we found a further breach relating to records and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Clarendon Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Clarendon Court accommodates up to 55 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of the inspection there were 54 people receiving a service.

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

Overall, people and relatives were complimentary about the care and support provided at the home. The home was very clean and well maintained.

In the main, any safeguarding concerns had been identified and reported appropriately to the local authority and CQC. However, we found two examples where local safeguarding procedures had not been followed. Staff needed to follow reporting procedures when the registered manager was not at the service.

Whilst in most cases action had been taken to mitigate any risks, records were not always complete and up to date. Staff spoken with could explain action taken to manage any identified risks more safely. However, care plans and risk assessments did not always provide staff with clear information and guidance about potential risks and how these should be managed.

Staffing levels were calculated using a tool based on the dependency of people living at the service. We reviewed the dependency tool which indicated that there were sufficient numbers of staff to meet people's needs. Staff were recruited using safe practices. People received their medicines safely, we noted that staff

needed to ensure they were aware when people needed regular monitoring, when taking certain medications.

People received sufficient to eat and drink and staff acted to address any concerns. However, we found in some cases that care plans were not always updated with the latest information. People were positive about the food available.

Where possible staff enabled people to make their own decisions and we observed staff obtaining verbal consent from people. Staff understood and complied with The Mental Capacity Act 2005 (MCA) and where people lacked capacity to consent we saw that mental capacity assessments and best interest decisions were recorded.

People were supported by suitably skilled and knowledgeable staff. Staff were up to date with training and received regular supervision and appraisals.

Staff were kind and caring in the way they approached people. People told us that were treated with dignity and respect. People received care that was centred around their individual needs and staff were aware of people's individual preferences. People and their relatives were included in decisions about their care.

Care plans were in place for each person. Those for wound care showed good evidence that specialist opinion was sought from the tissue viability team. Most parts of the care records were recorded well, however some care plans had not been consistently updated and records were not always signed or dated.

People could take part in person-centred activities and were encouraged to maintain hobbies and interests. The activities coordinator was very motivated. There were a range of activities available which people could choose to take part if they wished.

People and relatives were positive about the management of the service. They told us they were in regular contact with the staff and the registered manager, who was very approachable and were always kept up to date. Staff were positive about the support they received from the management team.

There were some quality assurance processes in place and audits were carried out on a regular basis. Despite the quality assurance and audit systems in place, these were not effective as care plans did not always record the needs of people adequately and safeguarding procedures had not always been followed.

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.

Improvements had been made to ensure safeguarding procedures were followed, however further improvements were required.

Whilst action was taken to assess and mitigate risks, records were not always accurate and up to date.

There were sufficient staff to meet people's needs and this was kept under review.

People received their medicines safely.

Is the service effective?

Good 

The service was effective.

People had sufficient to eat and drink and staff took action to address any concern. Records had not always been updated.

Staff understood the MCA and sought people's consent where appropriate.

People were supported by suitably skilled and knowledgeable staff.

Is the service caring?

Good 

The service was caring

Staff were kind and caring in the way that they approached people.

People were encouraged to express their views regarding the service and were involved in decision-making about their care.

People's dignity and privacy was respected.

Is the service responsive?

Good 

The service was responsive.

People received care that was centred around their needs.

Care plans detailed people's care and support needs, however these did not always contain up to date information.

There was a varied programme of activities available and people were positive about this support.

People knew how to make a complaint and felt able to raise any concerns with staff.

Is the service well-led?

The service was not consistently well-led.

Despite quality assurance and audit systems in place these were not effective.

People and relatives were positive about the management of the service.

Staff were motivated and positive about the management team.

There was a system in place to gain views from people and relatives on their experience of the care provided.

Requires Improvement 

Clarendon Court 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 13 and 15 June 2018 and was unannounced on day one. The inspection team consisted of two adult social care inspectors.

Before the inspection, we looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law. The registered manager had not received a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However we gathered this information during our inspection.

We contacted the local authority and they shared their current knowledge about the home. We checked to see whether a Health Watch visit had taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. A recent visit had taken place in March 2018 and the report was positive about the service.

During the inspection we spoke with nine people who lived at the home and four relatives/visitors, to seek their views. We spoke with 12 members of staff including two nurses, a care practitioner, three care staff, the registered manager, quality and compliance inspector, head of clinical standards, chef, activities coordinator and the maintenance person.

As some people living at Clarendon Court were not able to tell us about their care experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of six people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people.

Is the service safe?

Our findings

During our last inspection in August 2016 we found that safeguarding procedures had not always been followed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had taken action to address this and they were no longer in breach of this regulation, however some further improvements were still required.

In the main, any safeguarding concerns had been identified and reported appropriately to the local authority and CQC. The registered manager was clearly aware of the requirements to highlight and report any safeguarding concerns. However, we found two examples where local safeguarding procedures had not been followed, which left people at potential risk. For example, we saw that one person had bruising to their face. We reviewed their records and found that staff had logged the bruise within a body map. However, there were no other records available to confirm whether the cause of the bruising was known or had been considered. We raised this with the registered manager who was unaware of this issue and noted that they had been absent from the service in the days prior to the inspection. There was a risk that other causes of injury, including abuse, would not have been identified if they had occurred. We asked the registered manager to raise this as a safeguarding referral with the local authority, which was raised straight away. In another example we saw that a safeguarding incident had occurred between two people living at the service and this had not been reported through local procedures. The person's care records had not been updated following the incident to demonstrate that all appropriate action had been taken. We discussed with the registered manager the importance of all staff understanding reporting procedures so that appropriate action is taken when the registered manager is away from the home.

On the first floor, we saw that bedroom doors had small bolts on the outside, which we were told enabled staff to lock the bedrooms when they were not in use. This was to prevent people from mistakenly walking into other people's rooms. However, during the inspection, we saw that one person became accidentally locked inside their bedroom, this was because a staff member bolted the door without realising the person was inside. The person alerted staff within a few seconds; however, we were concerned about the potential risk of people being accidentally locked in bedrooms, especially those who would be unable to alert staff. We raised this with the registered manager and asked him to review this practice as soon as possible.

We found that whilst in most cases action had been taken to mitigate risks, records were not always complete and up to date. Risk assessments were in place which covered topics such as moving and handling and risk of falls. Staff spoken with could explain action taken to manage any identified risks more safely. For example, one person was at high risk of falling and staff had worked with health colleagues to reduce medications which may increase the risk of them falling. We observed that people had equipment needed such as profile beds, pressure relieving air mattress, bed rails with safety covers and sensor equipment.

However, care plans and risk assessments did not always provide staff with clear information and guidance about potential risks and how these should be managed. Some care plans had not been updated where a change in a person's needs was identified. We also found examples where risk assessments, such as for

moving and handling had not been fully completed or dated. This meant that accurate, complete and contemporaneous plans of care were not being kept.

One person had experienced several falls and slips from a chair. Staff told us that action was being taken to prevent the risk of falls and injury, such as crash mats and a sensor mat put in place. However, the person's care plans did not include this information to guide staff who may be unfamiliar with the person's needs. We saw further examples where records did not reflect changes to people's mobility needs.

In another example, we saw that one person was at risk of choking. An assessment had been made by a health specialist regarding the safest type of diet. Staff had been advised to arrange a best interest meeting to decide on the best approach with the person's relatives, this was in progress. In the mean time we saw that staff were providing a pureed diet to reduce the risk of choking. However, records were contradictory and confusing. We saw a notice on display which said the person required a different consistency of food and the person's care plans had not been updated to reflect the current guidance.

The service provider and registered manager had failed to ensure that complete and contemporaneous records were maintained in respect of each service user. This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that some of these issues would have been identified by the management team as the care plans concerned were due for an audit that month. We saw that the provider's quality inspector had undertaken an audit of the home in May 2018 which highlighted some issues around the completeness of records. Action had been identified to discuss at a staff meeting.

The registered manager told us that there were no staffing vacancies. Staffing levels were calculated using a tool based on the dependency of people living at the service. We reviewed the dependency tool which indicated that there were sufficient numbers of staff to meet people's needs. We reviewed rotas and saw that staffing levels could vary slightly on a day to day basis. The registered manager told us that on the days when there were fewer staff there were sufficient numbers to meet the needs of the people living at the home. Staff told us that overall, they felt there was enough staff to respond to people's needs effectively. However, there was some confusion about how the levels were calculated and the variations. For example, staffing varied on the second floor between two and three care staff and staff said this was dependent upon how many staff were in the building. During the inspection we observed only one member of staff on this unit during lunchtime whilst the other carer was on their break. We were concerned that some people required the support of two staff for moving and handling needs. The registered manager told us that staffing levels had recently increased on the second floor and assured us that the higher number of staff would continue on-going at the current dependency levels.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

People received their medicines safely. We checked the systems for the receipt, storage, administration and disposal of medicines in the home. There was a dedicated treatment room on each of the units, which were used to store and lock away medicines. Medication was stored in a locked medication trolley and in a locked treatment room to ensure only authorised people could access them. Regular audits on medications were carried out and the pharmacist had also carried out an audit. These audits were detailed and covered

all aspects in regard the management of medications. Staff had received the appropriate training which was regularly updated and their competency was regularly assessed.

Most of the records for the application of prescribed creams had been recorded and signed for daily. We carried out a sample tablet count of three boxed medication and found no discrepancies. We saw a system was in place to record the temperature of the medication fridge and treatment room temperature to ensure medication was stored at the correct temperature. We found no excessive stocks of medication being stored.

We noted that one person had a specialised medication, for which NICE guidance advises that people should have three monthly blood tests. This is to ensure the medication had not caused any other health problems. The nurse was unsure whether the person regularly had blood tests and had to check with the GP practice. A blood test had been undertaken in January 2018, and the nurse advised they would update the person's care records in include this information and ensure staff were aware of this monitoring.

The home employed a maintenance person who ensured that risks associated with the safety of the environment and equipment were identified and managed appropriately. A fire risk assessment had been completed and regular fire alarm checks had been recorded. Staff received training and knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP). Health and safety checks had been undertaken to ensure safe management of utilities, these included amongst others water and legionella checks, electrical appliance testing, regular checks and maintenance of moving and handling equipment, and the lift. There was an emergency plan which informed staff what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the home.

When we looked around each unit, we saw that a high standard of cleanliness was maintained. Personal protective equipment (PPE) such as disposable aprons and gloves were available throughout the home as was hand sanitiser, which would help reduce the risk of cross infection. Staff had undertaken training in infection control.

Is the service effective?

Our findings

People living in the home offered positive comments about the care and support provided. They said, "It's good, I like meals in my room, I have everything I need, occasionally I will have a drink, I have my own fridge with beer" Relatives were very positive and told us, "We are very happy, the care is very good", "Our relative has everything in their room, they put pictures up when they first moved in" and "They are doing a smashing job they are very good."

People received sufficient to eat and drink and staff acted to address any concerns. However, we found in some cases that care plans were not always updated with the latest information.

Discussions with staff and the registered manager demonstrated that people's nutritional needs were monitored. People at risk of losing weight were identified and staff maintained a "people at risk" form which included those at risk of weight loss. The registered manager also kept a matrix which recorded people's weights and any variations, so that changes could be followed up to ensure that appropriate action had been taken. Records evidenced that staff appropriately referred concerns to GPs and dieticians as necessary. However, whilst some people's plans and records showed they were putting weight on through support, other care plans did not reflect the action staff had taken to meet people's changing needs. In two examples people had lost weight, both were noted on the people at risk form and one had been previously seen by a dietician, however their care plans for nutrition had not been updated to include this information. It is important that information is accurate and up to date so that staff understand the level of support that people required. We raised this with the registered manager.

We saw that a MUST (Malnutrition Universal Screening tool) was used in some cases. This tool helps to calculate whether a person is at risk of losing weight. However, we found that there was some confusion about the appropriate use of the MUST tool. We saw one that had been calculated incorrectly therefore giving an incorrect risk score. The registered manager told us that the staff should not be using the MUST tool and that these documenters had been put into people's records in error. He told us that different types of nutritional assessments were used and would clarify this with the staff,

We spoke with the chef who understood people's personal preferences, including their likes and dislikes and any special diets such as diabetic soft diets/pureed or thickened fluids. She told us that kitchen staff were kept updated by nursing staff regarding any changes to people's nutritional needs. We observed lunch time in one of the dining rooms which was unrushed and people were supported by staff in a sensitive manner. There was a daily menu and people could choose whether they would like to eat in the dining room or in the privacy of their own. One person told us, "I choose to have my meals in my own room, this is what I like and they serve my meals to me every day." Generally, people were positive about the food provided and told us that they had plenty to eat and drink. We saw evidence that people who stayed in their bedroom had access to regular drinks and where required people were supported.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection, we saw that where possible staff enabled people to make their own decisions and we observed staff obtaining verbal consent from people. A member of staff said, "We always ask before we do anything." People told us that their wishes and decisions were respected. A relative explained how staff always asked if their relative was ready to get out of bed and respected their wish to have the occasional lie-in. Staff had undertaken training and understood the principles of the MCA. We noted in the care files that consent forms had been signed for the use of photos, to use specified equipment such as hoists, bedrails and covers and consent forms for the agreement to provide care and share information with relevant organisations. Where people lacked capacity to consent we saw that mental capacity assessments and best interest decisions were recorded. We saw that where Lasting Powers of Attorney for health and welfare decisions were in place for people living at the home, copies of these were held on their records.

DoLS applications had been submitted appropriately to the supervisory body (local authority). There were DoLS logs in place on each unit and the registered manager had a system in place when renewal applications were due to ensure authorisations were kept up to date. We checked that any conditions on authorisations to deprive a person of their liberty were being met.

People were supported by suitably skilled and knowledgeable staff. Relatives were positive about staff and said, "The staff are very good, we see the same faces for staff which is always good." We found that the provider was committed to the ongoing training and development of staff. Staff confirmed there was an induction process in place for new members of staff. The provider had a comprehensive training programme available and training involved a mixture of face to face training and an eLearning programme. Some clinical updates were provided by the Clinical Commissioning Group (CCG). We saw from training records that staff were up to date with all mandatory training including, safeguarding, MCA, health and safety and medication. Staff could request specific training and had undertaken further training in subjects such as diabetes management, end of life and dementia care. The provider supported staff with ongoing development for example with NVQ's and train the trainer courses. Staff offered positive comments stating, "If we think there something we need for training, the manager will sort it, we are well supported".

The provider had created a care practitioner role, which enabled care staff to undertake further training and increase their clinical skills. This required three months training and competency assessments. There were three care practitioners at the home who were also undertaking qualifications at a local university.

We saw from the records that staff supervisions and appraisals were undertaken on a regular basis with the management team. Staff felt they received good support and had received supervision sessions, where they could discuss anything with senior staff. They told us they were receiving appropriate support and guidance to enable them to fulfil their role effectively and were happy with the training on offer.

People's care records demonstrated how their physical and mental needs were assessed on admission to the home and reviewed on a regular basis. The registered manager usually met people and provided information about the home before they moved in. Care records also showed the service involved various healthcare professionals for example; GPs, district nurses and tissue viability nurses to meet the health needs of people who lived at the service. Staff provided examples where they had promoted people's health and well-being. For example, they told us about a person who had come to the home for end of life care

which was now over three years ago. Staff were proud of the level of support they had provided to keep the person as well as possible.

People's needs were met by the design and decoration of the home. Bedrooms were personalised with people's personal belongings, ornaments, pictures. Adaptations to the home were discussed with people and their relatives and their views were considered. A pub room and garden room had been created by the activities co-ordinator, as well as the creation of a café in one of the dining rooms.

People's names and photographs were displayed on bedroom doors to help people identify their rooms. The home's communal areas had recently been redecorated and the home was well furnished. The registered manager told us that there were plans to redecorate bedrooms. There was an outside seating area which people could access. The activities coordinator was developing a small seating area at the front of the building.

Is the service caring?

Our findings

People who lived at Clarendon Court told us they were happy and felt well cared for. They offered positive comments such as, "They are lovely [the staff]", "It's very nice here, they all work so hard, they are very good" and "Their attitude is nice." A relative told us, "She's well cared for and in good hands."

During the inspection we observed how well staff interacted with people. We saw that staff were kind and caring in the way that they approached people. The atmosphere was friendly and people living at Clarendon Court looked comfortable and content in their surroundings. We observed numerous examples of positive interactions between people and staff. For example, staff respectfully supported people to be hoisted into their wheelchairs, and we heard them quietly and sensitively explaining what they were doing and offering reassurance throughout the move. We saw that people were all well-groomed and appropriately dressed.

We heard staff and people living in the home communicating well with each other and we saw people freely expressing their needs. We saw that staff responded appropriately in supporting people. We observed a staff member always in attendance in one lounge offering one to one support and the same in the dining room during lunch time.

The service had received many thank you cards and compliments. One card received from a relative read, "You made [name] part of the family and always treated him well." People were supported to maintain relationships which were important to them. The Commission had received positive feedback from relatives who expressed their thanks for the care provided. Staff told us they would have no problems in recommending this service to their own relatives if needed.

During the inspection we saw that there were many visitors to the home. There were no restrictions on visiting and people said they were made to feel very welcome. One relative commented how they knew the staff well and that they felt "like family".

People were encouraged to express their views regarding the service and were involved in decision-making about their care. Care plan reviews were held with people and their relatives where appropriate. One relative told us how communication was good and how they were recently involved in care plan discussions. Information was contained within people's care plans about their individual likes and dislikes, hobbies and interests. Staff spoken with had a good understanding of people's individual backgrounds, histories and other important information. They told us they tried to support people in accordance with their personal preferences. For example, staff explained how they made sure that one person always had access to 1960s television programmes because these were their favourite.

People's diverse needs were considered. Care plans included people's cultural and religious preferences. Members of the local religious community visited the home which enabled people to practise their faith. Equality and Diversity was included within the provider's mandatory training requirements to ensure people were cared for without discrimination and in a way that respected their differences.

We observed staff interactions with people and saw they were good at respecting people's privacy and dignity. For example, we saw that a person had become a little distressed and needed support with their personal care. A member of staff responded quickly and supported the person in a kind, discreet and sensitive manner. Staff ensured that people staying in their own bedroom or cared for in bed were always protected, staff ensured each person had sufficient bed covers to protect their dignity and each person had access to the nurse call cord in case they needed the staff's assistance.

Staff used 'Me and my life' records to help them to get to know each person especially regarding their past and what was important to them. Some people chose not to complete these records and staff respectfully accepted their right to choose not to complete these records as they wanted complete privacy about their past and upbringing.

Information held about people who used the service was locked in a secure place when not in use. All staff had recently undertaken training regarding new legislation relating to the protection of information and we saw that these issues were discussed with staff during meetings. We saw staff take great care of support files making sure they were never left around and locking them up securely to protect their confidential information.

Is the service responsive?

Our findings

People living at the service told us, "I like to stay here and look out and watch the birds all day, they put the bird feeders there so I could watch them" and "I'm happy sat over here I can see the TV from where I'm sat". Relatives and people living at the home told us, "We have no complaints" and "Everything is fine, if we had a problem we would see the manager."

People received care that was centred around their individual needs. During our discussions with staff we found they were aware of people's individual preferences and the importance of this. Some people chose to stay in their bedroom as they liked the quietness and space, some people were supported to be cared for in their bed due to various health conditions. Staff told us that they respected people's individual wishes. For example, the various times of day that people preferred to shower. A member of staff explained that one person liked to spend time in their room during the afternoon to watch a favourite programme.

Staff tried to make sure people had everything to hand to help them within their own environment such as arranging for them to be able to see their TV whilst in bed and some people liked to listen to specific radio channels. Staff maintained daily records and charts to evidence that support had been provided to people. The registered manager told us that there had been a focus on these to ensure that they were completed fully and at the time the care was given. Those reviewed demonstrated that people had received support with food and drinks, personal care and positional changes.

Care plans were in place for each person and included mobility, nutrition, skin integrity, privacy and dignity, psychological support, end of life care and maintaining a safe environment. Care plans for wound care showed good evidence that specialist opinion was sought from the tissue viability team. Wound mapping records were used by staff to show progress with the management of a person's wound. Information about people's likes, preferences and life histories were also included.

Most parts of the care records were recorded well, however as reported in the safe and effective domains of this report, care plans had not been consistently updated and records were not always signed or dated. We saw that where care plans had been reviewed monthly, it was often recorded that there were "no changes". However, in some cases such as where people may have fallen or lost weight, further information should have been included to guide the staff. We saw that this had been identified by the provider's quality assurance team during an audit visit and some action identified to discuss with staff, however this has not yet proved effective.

Relatives told us they were involved and kept up to date if there were any changes to their relative's condition. They told us, "We met with the staff to review our relative's care plans and DNCPR to make it clear about her needs"

Staff considered people's communication needs. As part of their assessments people were asked whether they had any specific communication needs, which was recorded. Care plans contained information in

relation to supporting effective communication with individuals. This included information on any communication aids such as glasses or hearing aids that the person might require. The registered manager knew about the Accessible Information Standard and we saw posters on display which explained that information was available in alternative formats. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. We saw guidance available for staff on suitable methods for providing information to people living with dementia

People could take part in person-centred activities and were encouraged to maintain hobbies and interests. The activities coordinator was very motivated and knowledgeable about people's individual needs and preferences and developed activities in consultation with people and their relatives. There were a range of activities available which people could choose to take part if they wished. People were complimentary about the support provided.

Posters displayed the programme of activities which offered good visual prompts. Activities on offer included, quizzes, bingo, cabaret shows, film club, residents and kids activity club. There were also pamper days hair and nails, movement classes, papers and magazines, musical singalong, and arts and crafts. During the inspection we observed a lively karaoke session. The activities coordinator also provided one to one support for people who preferred to stay in their bedrooms. Links had also been developed with the wider community, such as a local nursery, who visited regularly. A local wild life sanctuary also visited with owls and a local store supported with fund raising.

People felt able to give feedback about the service. We saw that regular residents and relatives' meetings were held. The provider had a complaints procedure in place, which was on display in the reception at the home. The registered manager logged any complaints, which were documented with any actions taken to resolve them. There was a current complaint in progress, which we discussed with the quality inspector and saw that the provider was investigating. We were advised that a full outcome would be sent to the complainant when completed. There had been five complaints in the past 12 months, which had been fully investigated and appropriate responses were provided.

People's care records showed that they had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information. People also had 'advanced care plans' in place and where appropriate their next of kin had been included in planning their care in the event of their deterioration. Staff had organised a specific medical device called a driver to administer specialist medication which was recorded within their medication procedures. Nursing staff had completed training in end of life care and two were undertaking extra training with a local hospice.

Is the service well-led?

Our findings

People and relatives were positive about the management of the service. They told us they were in regular contact with the staff and the registered manager, who was very approachable and were always kept up to date.

There continued to be a manager who was registered with The Care Quality Commission (CQC). The registered manager was available throughout the inspection and engaged positively with the inspection process. They demonstrated good knowledge of all aspects of the home including the needs of people living there and the staff team. Documentation was available on request throughout the inspection. The registered manager understood his responsibilities and was supported by a wider team, including a deputy manager, quality assurance and regional manager. The registered manager had regular contact with people and their relatives; his office was based in the reception area and we saw that he had built effective relationships with people and visitors.

There were some quality assurance processes in place and audits were carried out on a regular basis. There was a schedule of audits which had been completed including medication, care plans, infection control, dining experience and confidentiality monitoring. The provider employed a quality and compliance inspector who undertook monthly monitoring visits to the home. An action plan was developed if there were any issues identified and reviewed at the next visit.

Despite the quality assurance and audit systems in place, these were not effective as care plans did not always record the needs of people adequately and safeguarding procedures had not always been followed. Some issues had been noted regarding the completeness of records in a quality audit in May 2018 and effective action had not yet been taken to address these issues. During this inspection the provider did not meet all the standards set out in the regulations. Further improvements to the quality monitoring process therefore needs to be made to ensure there is a clear overview of practice within the service and therefore well led.

Sufficient recording systems were not always in place. For example, inside an unused medication cupboard there were items of jewellery stored, some items were sealed in an envelope and some were loose. There was no written audit trail to show safe storage and to show when the jewellery was found or information to show attempts to locate this back to people or their family. We raised this with the registered manager.

These issues were a further breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were motivated and positive about the management team. Those spoken with were clear about their own roles and responsibilities. They all told us there was a friendly atmosphere within the service and they felt very much part of a team. Staff felt well supported and knew who to go to with any concerns. They felt any concerns raised would be dealt with appropriately. They told us, "The manager is brilliant, you can go to him about anything, he will listen to you, you could go to him to whistle blow if needed", "I feel very

supported by (name) and (name), the management is very good" and "Brilliant support from the manager, I can suggest things and get support."

Regular staff meetings took place to share information and to look at what was working well and where any improvements needed to be made. Staff told us they could raise any issues at staff meetings. The registered manager or deputy routinely observed the care being provided and carried out a daily walk round of the home to check that everything was in order.

There was a system in place to gain views from people and relatives on their experience of the care provided. The registered provider sought people's feedback through an independent survey, one was carried out for 2017/18. We saw that information was displayed in the reception area about the feedback received. Resident and relatives' meetings were held on a regular basis. Minutes of these demonstrated that a people's views about the service were sought and a range of issues were discussed.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. This is called a notification. We checked our records and found that the registered manager had made the appropriate notifications to CQC as required. The current CQC rating was displayed as legally required on the registered provider's web site and within the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider had not ensured that an accurate, complete and contemporaneous record was always maintained for each person. The provider had not ensured that quality systems to monitor the service were effective.
Treatment of disease, disorder or injury	