Giltbrook Carehomes Ltd

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 April 2017 and was unannounced.

The provider is registered to provide accommodation for up to 40 older people living with or without dementia in the home over two floors. There were 30 people using the service at the time of our inspection. The home provides nursing care for older people.

At our last inspection on 20 and 21 April 2016, we asked the provider to take action to make improvements in the areas of medicines, safeguarding service users from abuse and improper treatment and good governance. We received an action plan setting out when the provider would be compliant with the regulations. At this inspection we found that the concerns in the area of medicines had been fully addressed. However, while improvements had been made, more work was required in the other two areas.

A registered manager was in post and was available throughout the inspection. 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.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. However a staff member did not report a potential safeguarding issue. Risks to people's safety were not always assessed and managed.

Sufficient numbers of staff were on duty during our inspection to meet people's needs, however, sickness levels were reported to have an effect on staffing levels especially at weekends. Staff were recruited through safe recruitment processes. Safe medicines management and infection control practices were followed.

Staff received appropriate induction, supervision and appraisal but training required improvement. People's rights were protected under the Mental Capacity Act 2005 but documentation supporting decisions could be improved. People were supported by staff to have sufficient to eat and drink but food and fluid charts were not well completed.

External professionals were involved in people's care as appropriate. People's needs were not fully met by the adaptation, design and decoration of the service.

Most staff were kind and caring, however, staff did not respond in a caring way to two people in distress. People and their relatives were not fully involved in decisions about their care. Advocacy information was made available to people. People received care that respected their privacy and dignity and promoted their independence.

Activities required improvement. People did not always receive personalised care that was responsive to their needs.

Care plans contained sufficient information to guide staff to provide personalised care for people. Complaints were appropriately responded to.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. This is the third consecutive inspection where these issues have been found. As a result the provider was not fully meeting their regulatory requirements. People and their relatives were involved or had opportunities to be involved in the development of the service.

We found one breach of 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. However a staff member did not report a potential safeguarding issue.

Risks to people's safety were not always assessed and managed.

Sufficient numbers of staff were on duty during our inspection to meet people's needs, however, sickness levels were reported to have an effect on staffing levels especially at weekends.

Staff were recruited through safe recruitment processes. Safe medicines management and infection control practices were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received appropriate induction, supervision and appraisal but training required improvement.

People's rights were protected under the Mental Capacity Act 2005 but documentation supporting decisions could be improved. People were supported by staff to have sufficient to eat and drink but food and fluid charts were not well completed.

External professionals were involved in people's care as appropriate. People's needs were not fully met by the adaptation, design and decoration of the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff were kind and caring, however, staff did not respond in a caring way to two people in distress.

People and their relatives were not fully involved in decisions about their care. Advocacy information was made available to

people.

People received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities required improvement. People did not always receive personalised care that was responsive to their needs.

Care plans contained sufficient information to guide staff to provide personalised care for people.

Complaints were appropriately responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. This is the third consecutive inspection where these issues have been found. As a result the provider was not fully meeting their regulatory requirements.

People and their relatives were involved or had opportunities to be involved in the development of the service.

Giltbrook 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 4 and 5 April 2017 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with three people who used the service, three families, a domestic staff member, a laundry staff member, a kitchen staff member, a maintenance person, a care staff member, three senior care staff members, a nurse, the registered manager and a representative of the provider. We looked at the relevant parts of the care records of seven people, four staff files and other records relating to the management of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the provider to send us their provider visit reports after our visit. The provider did this.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection in April 2016 we found that appropriate actions were not always taken to respond to potential safeguarding issues. The provider was found to be not compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent an action plan to tell us how they would become compliant with the regulation. At this inspection we found that this regulation had been complied with but further improvements were needed to ensure all potential safeguarding incidents were properly recorded.

We observed one person who used the service was deliberately banged on the shin, by another person with their wheeled walker as they passed by. A staff member saw the incident and made sure the person was okay. The person also told us later that they were unhurt. Staff said they were encouraged to report incidents. A staff member said, "We always fill in an incident form." However, an incident form was not completed for this incident. This meant that there was a greater risk that appropriate actions would not be taken in response to this potential safeguarding incident. We raised this with the registered manager who told us they would be reminding staff of their duty to report all incidents.

People told us that they felt safe in the home, although a number of people reported incidents of other people living with dementia walking in and out of their bedroom occasionally, day and night. A person said, "It's a safe home. I get the odd person walking round my room now and then. They don't talk, just walk round, look and go out again. I'm not really frightened as they don't do anything. I ring my bell sometimes if it's at night." Another person said, "I'm alright here and feel secure. I have the occasional person wandering in my room, it worried me at first but not now. I tell them to clear off." A relative said, "[My family member] is very safe. The staff are caring and [the registered manager] makes sure someone is sat in the [lounge] with them." We observed three people living with dementia who frequently walked up and down the ground floor corridor unsupervised, with one person opening bedroom doors as they went.

Staff were aware of safeguarding procedures and the signs of abuse. They said they would report any concerns to management and contact the local authority safeguarding team as necessary. A safeguarding policy was in place and information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety. Staff had attended safeguarding training. Appropriate safeguarding records were kept when referrals had been made.

During our previous inspection in April 2016 we found that safe medicines practices were not always followed. The provider was found to be not compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent an action plan to tell us how they would become compliant with the regulation. At this inspection we found that improvements had been made and the regulation had been complied with.

People told us that medicines were well managed. A person said, "Of course someone stays while we have tablets, like they're supposed to." A relative said, "[My family member]'s insulin is well managed by the nurse." Staff administering medicines told us they had completed medicines training and received

competency checks for medicines administration. Records confirmed what we were told.

We observed the administration of medicine; staff checked against the medicine administration records (MAR) for each person and stayed with the person until they had taken their medicines. We noted a person was prescribed medication which should be given at specific times but the morning dose of medicine had been given over an hour late. This might affect the effectiveness of the medicine and we discussed this with the staff member. They told us the person was sometimes reluctant to take their medicines earlier, however, they agreed to ask staff on the earlier shift to administer the medicine and discuss the issue with the person's GP if the person continued to be reluctant to take the medicine at the times prescribed.

Most MARs contained a photograph of the person to aid identification, a record of any allergies and information about the person's preferences for taking their medicines. We mentioned the missing photographs on some MARs to the nurse on duty and later in the day they told us they had taken photographs for those people without them. MARs were completed consistently, however, handwritten additions to the MAR were not always signed by two staff members to confirm that they had been checked for accuracy. We also saw that not all liquid medicines had been dated when opened to ensure they were only used within the time period when they remained effective. This meant that there was a greater risk that people would receive ineffective or incorrect medicines.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability. Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. When medicines were prescribed to be given only when required protocols were in place to provide staff with guidance on when to administer the medicines.

People told us that they were kept safe but not unnecessarily restricted. They told us they could move around the building as they wished and were able to. A person said, "I can use the lift and go up or down or anywhere." Another person said, "I walk round with my frame downstairs where I want to go or sit. I join in things if I feel like it."

People told us that staff assisted them to move safely. A relative said, "They use a [piece of moving and handling equipment] for [my family member] and seem to manage well. I've no issues with their help." We observed good moving and handling practice. A person was encouraged to use a moving aid appropriately and when they had difficulty staff gave them time and tried again several times, staying with the person and not hurrying them. When they continued to have difficulties, staff went to obtain a hoist. However, when they returned with the hoist, they gave the person another opportunity to use the other moving aid and they did this safely.

A person said, "They come two hourly to move me round." Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. We looked at the documentation for two people at risk of skin damage who required the support of staff to change their position. The documentation indicated that the people were not always re-positioned as frequently as required in their care plan. We noted that a person's care plan for the prevention of pressure ulcers stated they should be assisted to move their position every two hours. We reviewed their re-positioning charts and saw that there were gaps of 10 hours and above at the weekend. Another person, whose position should be changed every two hours, had gaps in their re-positioning record of eight hours and above at the weekend. If the documentation was an accurate reflection of the care provided then people were placed at risk of avoidable harm. Staff told us that they were confident that people received appropriate support but

documentation was not always fully completed. We raised this with the registered manager who told us they would be reminding staff of their duty to complete this documentation.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals. A staff member told us of action they had taken to reduce people's risk of falls such as referring people to a physiotherapist, asking for a medicines review and ensuring people used appropriate walking aids. However, we saw that accidents and incidents were not regularly analysed to identify any trends or themes so that actions could be taken to reduce any risks of them happening again. The registered manager told us that an analysis would be taking place in the future.

Risks to people's health and safety were assessed including their risk of falling, developing pressure ulcers, and nutritional risk. When bed rails were used to prevent people falling out of bed risk assessments were completed to ensure they could be used safely. Risk assessments were reviewed monthly. Care plans were in place to reduce these risks.

Checks of the equipment and premises were taking place but action was not always taken promptly when issues were identified. Hot water temperatures were not being consistently monitored or responded to. This has been an issue at previous inspections of the service. Fire drills and actions to minimise the risk of legionella were not always taking place. The registered manager told us that she would take action to address these issues.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

We received mixed views on the level of staffing, with most people feeling that more staff were needed, particularly at weekends. A person said, "No, there aren't enough [staff] on. I think there should always be one in the lounge and in the dining room. I sit and see times when no-one's around and people try to walk off." Another person said, "No, I don't think there's enough [staff] around. No particular time, just any. They need more hands, mostly around in the lounges." A relative said, "It seems mainly okay from what I notice on my short visits." However, another relative said, "We've an issue with low staff at weekends. In the week it's not so bad." A third relative said, "They can seem very stretched and at weekends they're always on a skeleton staff."

Domestic, laundry and kitchen staff all felt that they had sufficient time to complete their work effectively. A care staff member said, "Staffing levels are usually pretty good. However we have been short staffed due to staff sickness. Care was still provided and no one was put at risk." Another member of staff told us that when planned staffing levels were achieved, sufficient staff were on duty to meet the needs of people they cared for. However, sickness levels were high and this had an impact as they could not always be replaced. A third care staff member felt that staffing levels had improved and were sufficient to meet people's needs.

On the first day of inspection we were told that two staff had phoned in sick. However, other staff were contacted and the home was fully staffed just after 10am. One person who was still in bed when we checked at 10am told us they would have preferred to have got up earlier. However, they also told us they were normally able to get up earlier if they wished. During our inspection, we saw that people were promptly responded to but communal areas and corridors were not always supervised by staff. This meant that some

people walked into other people's bedrooms without staff supervision. It also meant that there was a greater risk that staff would not available to promptly respond to people in communal areas if they requested assistance.

Systems were in place to identify the levels of staff required to meet people's needs safely. The registered manager explained that they considered people's dependencies when setting staffing levels and monitored them closely to ensure that staffing levels remained at the correct level. A staffing tool was also completed which concluded that identified staffing levels were appropriate to meet people's needs safely. Staff rotas showed that staffing levels were affected by staff sickness and the registered manager and provider told us that further care staff were being recruited to ensure short notice sickness could be responded to.

Safe staff recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

A relative said, "The cleanliness is very good really, but sometimes there's a wee smell." Upon arrival at the home on the first day of inspection, we noticed some areas which were malodorous. However, when we checked later in the day there were no smells in these areas. We observed that the environment was generally clean and staff followed safe infection control practices at all times.

Requires Improvement

Is the service effective?

Our findings

People told us that staff appeared to be trained and capable in their role. A person said, "They're very good and know what they're doing." A relative said, "They seem to cope with people okay."

A staff member told us they had been given an induction and had shadowed another member of staff in the same role for three shifts including a night shift. The registered manager had checked their training certificates, they had completed most mandatory training and were scheduled onto the next training courses for the subjects where they required an update.

Other staff told us they had received an induction and felt they had received the training they needed to meet the needs of the people who used the service. However, training records showed some staff with gaps in a number of areas including Dementia, MCA, DoLS, food hygiene, equality and diversity, health and safety and infection control. We discussed the matrix with a staff member who said they had attended more training than was recorded and the matrix was not up to date. Staff told us they had received regular supervision and appraisal and records confirmed this.

People told us that they could not always recall staff asking for consent. A person said, "They ask me nicely first." However, another person said, "They just come and tell me really what we're going to do next." We saw that staff generally asked permission before assisting people and gave them choices.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Mental capacity assessments were completed and best interest decisions considered when people were unable to make some decisions for themselves but the specific decision and alternative options considered, were not always clearly documented. We also saw that an assessment and best interests documentation had not been completed for the disclosure of specific information affecting a person who used the service. The registered manager agreed to review this. DoLS applications had been made where appropriate.

Most care records contained guidance for staff on how to effectively support people with behaviours that might challenge others. However, whilst there was considerable detail in the care plans, they tended to be generalised information about the way dementia affects people and their behaviour rather than specific information as to how this manifested in the person themselves. Guidance was not in place for one person,

however, staff were able to explain how they supported that person and other people with periods of high anxiety and we observed staff effectively support people with behaviours that might challenge others.

We looked at the care records for people who had a decision not to attempt cardio-pulmonary resuscitation order (DNACPR) in place. We saw that one DNACPR form did not specify whether it required reviewing at intervals, however, a member of staff had flagged that the GP should be asked to review it at their next visit to the service. Other DNACPR forms had been fully completed.

Most people we spoke with were satisfied with the choice of food offered and alternatives available. A person said, "It's very nice food. They bring a tray round with samples of meals so we can see and choose. There's fruit and snacks on the lounge trolley we can help ourselves to." A relative said, "[My family member] has put weight on since being here and is so much better."

People told us that drinks were readily available. A person said, "I like my jug of squash and have a glass of milk sometimes. My [relative] brings in flavoured fizzy water which makes a change. So I have lots to drink." A relative said, "[My family member] always has a drink to hand."

We observed lunchtime on the first day of inspection. Tables were laid and food was well cooked and nicely presented. People who required support to eat were patiently assisted by staff. However, people were not always effectively supported to make choices about their meals. There was no pictorial menu or simple description of the meals, for use by people living with dementia. Visual options of the dessert were shown to several people but were not effective as both sponges were covered in custard and indistinguishable.

Nutritional risk assessments were completed and people's weights were monitored regularly. We saw that when a person had lost weight, the person's GP was contacted and a referral was made to a dietician. Following review by a dietician, care plans were updated and the advice of the dietician followed. The person continued to be monitored and the dietician was asked to review the person again when staff identified the volume of the supplements prescribed, was impacting on their food consumption at meal times. Further changes were then put into place.

Food and fluid charts were either missing or poorly completed. This meant that documentation was not being accurately completed and there was a greater risk that concerns might not be promptly identified to allow action to be taken to minimise their risk of avoidable harm. We raised this with the manager who told us that they would remind staff of their duty to complete this documentation.

People were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. A person said, "The chiropodist comes about every six weeks I think and I had the optician. I like getting my hair done, and a manicurist lady comes in to do our nails once a month." A relative said, "The doctor comes regularly to check [my family member]."

Care records contained evidence of the involvement of a range of healthcare professionals when this was required. We saw evidence of the involvement of chiropodists, opticians, speech and language therapists, dieticians, a tissue viability nurse and family doctors. People received responsive dental treatment when required and the registered manager told us that further work was taking place to ensure that people received preventative dental checks.

Some adaptations had been made to the design of the home to support people living with dementia, however more work was required. Bathrooms, toilets and communal areas were clearly identified and a sensory room had been created in the small lounge by the activity staff, to give residents an opportunity to

relax. However, the bedroom corridors were generally long and plain and not obviously zoned by the use of colour or decoration to enable people, especially if living with dementia, to find their bedroom easily. Some people's individual bedrooms were not easily identifiable and there was no directional signage to support people to move independently around the home.

We also noticed that the call bell alert, a single high pitched buzz, was quite often in use and could be heard clearly in the communal areas, corridors and bedrooms. The noise was quite intrusive, especially for people with sensitivity to noise or disturbance. Similarly, the landline phone had bell points around the corridors and was a loud disturbance at intervals.

The long ground floor corridor with communal rooms located along it became congested at times and people using a walking aid or in a wheelchair often had to give way to one another or staff. A number of residents living with dementia also frequently walked up and down the route. Some people had behaviours that might challenge and the width of the corridor meant that there was a greater risk for potential incidents between people.

We also noticed that some carpet areas of bedroom corridors in the older part of the building were stained, well-worn and in need of replacement. The registered manager told us that plans were in place to address this issue.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. A person said, "Oh yes they're so kind. We have many a laugh in here." Another person said, "They're kind and caring people." A visitor said, "The majority are very good and kind."

We saw a good example of caring attitude after lunchtime. A carer who had been upstairs came into the dining room and put her arm around a person who was enjoying a large pudding portion and shared a joke about having a pudding on her diet. She chatted to the other two people at the table while she helped with offering seconds of pudding and drinks. They shared several jokes with good humour and there was excellent interaction. We also saw the activity co-ordinator interacting well with residents in the lounge, spending time talking with individuals.

However, we overheard two examples of poor interaction where staff did not react to a person in distress in a caring way. Whilst passing a shut bedroom door, we heard a person in distress and calling out a number of times. We heard a staff member in the room twice say "[Staff member's name] let go!" whilst carrying out some personal care. There was no other conversation for several minutes until we heard the staff member eventually say "That better? Are you hungry?" and they left the room. The staff member had not reassured the person while they were providing care. While passing another shut bedroom door, we heard another person in distress who was receiving personal care from staff. The person became increasingly distressed and we were told hit a staff member in the face. The person's care records contained guidance for staff on providing the person with personal care but staff had not followed this. We raised this issue with the registered manager who took appropriate action.

People told us they had not seen their care records. We received mixed feedback from relatives on their involvement in their family member's care, with only some having seen care plans and feeling involved. A person said, "My [relative] comes in and does legal things for me. She takes charge and tells me what's happening." A relative said, "It's my [other relative] who has power of attorney for [my family member] and has had a few meetings here over the recent years." Another relative said, "I'm next of kin so I do the finances and my [other relative] keeps an eye on the care side. I've not seen [my family member]'s care plan before but I know my [other relative] has just seen it."

Care records contained a care plan in relation to people's involvement in their care and care planning. These documented the person's ability to make decisions for themselves and indicated they or their family should be involved in decision making. However, we did not find evidence of their involvement. No regular care reviews were taking place with people and their relatives. Care records did contain information that suggested that people and their relatives had been involved in discussions about care but this was not formally documented or scheduled. The registered manager told us that this would be taking place in the future.

Where people could not communicate their views verbally their care plan identified how staff should identify their preferences. Advocacy information was available for people if they required support or advice from an

independent person. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People told us that their privacy and dignity were respected by staff. A person said, "[Staff] knock first and my curtains get shut. They're pretty good at keeping us private." A relative said, "[My family member] can be private in her room if they want. I see the girls knock and pop in."

We observed staff knocking on bedroom doors before entering and keeping doors and curtains closed during personal care. We saw staff adjusting people's clothing to maintain their dignity. Staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

People told us they were supported to be independent where possible. A person said, "Of course they like us to do as much as we can ourselves." Another person said, "[Staff] watch you but let us try to do things first." We saw staff encouraging people's independence when assisting them to move and at mealtimes.

Relatives were able to visit their family members without unnecessary restriction. A person said, "They can come in and see me any time." A relative said, "We have no ties on coming in unless there's a bug going round."

Requires Improvement

Is the service responsive?

Our findings

People's feedback on activities was mixed. A person said, "I like the bingo and beanbag games. The music people are good too. The church comes to do a monthly singsong which I like. I've made a friend so we often sit together in the day. The one thing I miss is going out on trips. The garden will be nicer when it's warmer." Another person said, "We don't get a lot to do, a singer or bingo now and then. My friends take me for a walk sometimes to Ikea or Eastwood in a wheelchair." A visitor said, "They have things on for them, like an artist came in, and she likes doing the bingo and dominoes." Another visitor said, "The activity staff are wonderful and try and keep people doing things."

On the first day of our visit, we observed a game of bingo taking place in the main lounge. The activity co-ordinator told us that they aimed to provide a minimum of one group activity a day, seven days a week if possible. They hoped to be able to plan trips out over the summer if appropriate transport could be arranged. A member of staff said they felt people had enough activities and said, "There are a lot more activities here than in some other homes. The activities here are pretty good." They said they took people out when they could and mentioned that one person liked to go to the local newsagents and although they were not able to go independently, staff accompanied them there when they could. Activity records showed that people attended group activities and there were also some 1:1 activities, however, most people were not supported to access activities outside of the home.

People we spoke with told us that staff enabled them to make day to day choices and they felt their care was personalised to them. A person said, "I have things done for me which I like. I'm not in a queue for someone to come." However, we saw that people who walked up and down the ground floor corridor did not always receive care that met their personalised needs. Staff did not always interact with them in a timely manner and as a result, we saw that one person opened other people's bedroom doors disturbing people who were in their rooms at the time.

People told us that call bells were not always answered in a timely manner. A person said, "It varies, it can be a longer wait if the girls are on a break. It's often five minutes or more so I just keep pressing. I've not had an accident from waiting though." Another person said, "They're pretty quick coming but sometimes it's been about 15 minutes." We observed that call bells were generally promptly responded to during our inspection.

People told us that they were not asked whether they had a preferred gender of care staff to support them. A person said, "They don't ask us. They just assume we don't mind who it is. I'm not unhappy with it though." Another person said, "I've not been asked but I don't mind either."

Staff had completed 'This is Me' documentation which provided information on people's life history and personal preferences. Care plans were detailed and contained guidance on people's personal preferences. Care plans were reviewed monthly to ensure they remained up to date. Care plans for people's nursing care needs contained the essential information staff required to provide personalised care.

People told us they felt able to speak to staff or the registered manager to raise any concerns. A person said

"There's just been an occasional little thing that gets put right straight away." Another person said, "We had to complain when [my family member] said that one of the staff hadn't been nice and it had really upset them. We were told that the staff member got asked to leave."

We looked at a recent complaint which was responded to appropriately. Guidance on how to make a complaint was displayed in the home. There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them. Staff told us they would refer any complaints to the registered manager but they would try to resolve issues immediately if they could.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspections in May 2015 and April 2016 we identified that that the systems in place to monitor the safety and quality of the service were not always effective. The provider was found to be not compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had been made but the regulation had still not been complied with and more work was required to ensure that systems were fully effective to identify and address all the issues we found at this inspection.

We saw that the service's management team had completed audits including the areas of kitchen, medicines, care plans, health and safety and infection control. Representatives of the provider had also completed regular reviews. However, action plans were not always in place where required and these audits had not identified and addressed the issues we found at this inspection.

The CQC inspections in 2011, 2012, and 2013 identified breaches in regulations. The inspection in July 2014 found that all regulations had been complied with, however, at the inspections in May 2015 and April 2016 the service was rated 'Requires Improvement' and we identified a number of breaches of regulations and a number of areas were also identified as requiring improvement. While there had been improvements not all areas had been fully addressed by the time of this inspection. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No-one we spoke with could recall a formal feedback request from the provider. However, general comment cards were available in the reception area. A person said, "Someone asked me if everything was okay for me." A visitor said, "There are comment cards on the desk if we want to do one." Another relative said, "I've seen cards on reception but haven't done one."

Some people had been to meetings to discuss their views of the service. A person said, "They had a meeting in the dining room and we had our say but I didn't notice any changes." A relative said, "My daughter has been to one in the past but I know nothing more." Another relative said, "I've seen meetings listed but can't get to them.

We saw that meetings for people who used the service and their relatives took place. We saw that actions, such as the tea time being moved to an earlier time, had taken place in response to comments made at meetings. Surveys had been sent to relatives, however, we saw that the service used a survey which was not easily understandable and the provider agreed to review the survey to make it more accessible in order to gather the views of people who used the service. Survey comments from relatives were generally positive.

A whistleblowing policy was in place and staff told us they would be prepared to raise issues using the processes set out in the policy if necessary.

The provider's values and philosophy of care were displayed on the wall and were in the guide provided for people who used the service. However not all staff acted in line with those values at all times.

We asked people their views on the general atmosphere of the home. A person said, "It's very good." Another person said, "We get ups and downs so it never feels the same." A relative said, "It feels okay." A staff member said, "This a nice, friendly home."

People told us that they found the registered manager visible and approachable. A person said, "I see her about now and then. She'd be easy to talk to about things." Another person said, "We see her in [the lounge] sometimes and we can tell her our worries." A relative said, "The [registered] manager has made improvements like far better supervision of people, new lounge chairs and other good things. We can see her any time in the office." Another relative said, "[The registered manager] answers any questions we have and is easy to find." A third relative said, "We get on well with her, she's wonderful."

A member of staff said that since the last inspection, "We have worked really hard to make a difference for the residents." They told us there had been a change in the attitude of staff and new staff had been appointed who, "were prepared to work as a team." Another member of staff said, "[The registered manager] is very supportive and you can talk to her if there are any issues." They said, "It is all about the residents and improving things for the residents." They said, "She listens to suggestions and looks at whether we can do things differently." They told us there had been a staff meeting a few days previously. They said, "It was well attended, nearly everyone came in." Other staff told us that staff meetings took place where the management team clearly set out their expectations of staff. Records confirmed this.

A registered manager was in post and was available throughout the inspection. They told us that they felt well supported by the provider. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b)