Anchor Carehomes (Hyde) Limited

Hatton Grange

Inspection report

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Date of inspection visit:
26 September 2016

Date of publication:
25 November 2016

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

This inspection took place on 26 September 2016 and was unannounced. At our last inspection of the service on 14 November 2013 the registered provider was compliant with all the regulations in force at that time.

Hatton Grange is situated in the Hyde area of Tameside and has good access to local transport routes. The establishment is a large purpose-built service, which provides 24 hour care and support for up to 70 people who require residential care without nursing. The property has three floors with a residential care unit and a dementia care unit on each floor. The ground floor units are named Millwood, the first floor units are Kingston and the second floor units are Carrfield. All bedrooms are for single accommodation and have en-suite shower facilities. At the time of our inspection there were 67 people using the service.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We have made some recommendations in this report in relation to staffing levels, maintenance and the environment. Although the registered provider took action to improve these areas following the inspection, they should have been recognised and prompt action taken using the service's own quality assurance process. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service. Until the service was fully staffed the service was using agency staff. The same staff were booked to aid the continuity of care for people using the service, however the agency staff were not always reliable at turning up. The staff team worked well together to ensure the needs of people were not affected by any dips in staffing levels and there was a good atmosphere in the service. However, staff told us they felt stressed and tired with trying to manage without enough staff on duty. People had access to a range of social activities and events within the service, but activities during the afternoon were sometimes compromised when there was a shortage of care staff to carry them out. We received written confirmation from the district manager that the registered provider had agreed to increase the staffing levels within the service shortly after our inspection. We have made a recommendation in the report about this.

Health and safety checks were carried out by maintenance staff and maintenance certificates were in place. However, there were a number of actions outstanding on the electrical wiring certificate and the fire risk assessment, which were dated August 2016 and March 2016 respectively. We received written assurances from the district manager and registered manager following our inspection that all these repairs and action points had been completed. We have made a recommendation in the report about this.

The registered provider had an induction and training programme in place and staff were receiving regular supervision. People were confident in the staff skills and knowledge and said they received good care and support. However, staff had not received training on management of distressed or agitated behaviours which they felt would be of benefit to them in meeting the needs of current people using the service. We have made a recommendation in the report about this.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and staff had been employed following robust recruitment and selection processes.

Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plentiful drinks throughout the day.

People were included in decisions about their care and we saw that appropriate care and support was being offered to people who used the service. We observed a number of positive interactions between the staff and people they were caring for. People received a detailed assessment to determine if the service was right for them. The care plans were person-centred and included input from a range of professionals.

People were treated with respect and dignity by the staff. There was a formal complaints system in place to manage any complaints received.

The registered manager supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people and relatives about the care and support offered by the service.

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

Some aspects of the service were not safe.

Staff had been employed following robust recruitment and selection processes. Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service. However, better monitoring and assessment of staffing levels was required to ensure staffing levels were adequate at all times.

The registered provider addressed some issues with maintenance, repair and renewals shortly after our inspection. However, these should have been dealt with in a timely manner as part of the risk assessment process within the service.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and staff demonstrated a good understanding of safeguarding adults procedures. Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plentiful drinks throughout the day.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience when supporting people. Clear explanations were given to people as tasks were carried out by the staff. This meant people understood what was happening when receiving assistance and support.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive.

We found that people received the care and support they required to maintain their health and wellbeing. Staff were able to tell us about people's care needs and demonstrated a good knowledge of their health care conditions.

People had access to a range of social activities both inside and outside of the service. There was a minor impact on those taking place when staffing levels were low, but people said they were satisfied with the choice available.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The quality assurance system was not robust and did not always protect the health and safety of people using the service.

People who used the service said they could chat to the registered manager and relatives said the registered manager was understanding and knowledgeable.

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

Hatton Grange

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 26 September 2016 and was unannounced. The inspection team consisted of three adult social care inspectors.

As part of the inspection process we contacted the local authority safeguarding adults and commissioning teams to enquire about any recent involvement they had with the service. We were told they did not have any concerns about the service other than the levels of staffing. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the district manager, registered manager, deputy manager and eight staff. We also spoke with one visitor and four people who used the service. We carried out observations on all six units of the service and walked around the whole building.

We spent time in the office looking at records, which included the care records for seven people who used the service, the recruitment, induction, training and supervision records for four members of staff and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We had asked the local commissioning team about their views of the service prior to our inspection. They told us that they had received a number of concerns in the last year from families who were concerned about the level of staffing in the service. When we asked people who used the service and relatives if there were enough staff on duty we received a mixed response. Some felt there were enough on duty but others said there were times they were short staffed.

One person said, "There are enough staff, they are all 'the right kind of person'. There is always someone around when you need them and they are quick to answer the call bell." Another person said, "There are not enough staff around." One visitor told us, "I cannot complain about the care my relative receives as the staff are extremely good at meeting their needs. However, the staff are rushed off their feet and there does not seem to be enough of them at times."

There were 67 people in the service and the staffing levels were usually 12 care staff on duty over the three floors. According to the registered manager there should have been three care staff and one senior care staff on each floor (two per unit). The senior member of staff was responsible for administering medicines on both units on their floor. This meant at certain times of the day there could be only one member of staff on a unit, whilst the senior staff was busy with medicines and visiting medical professionals. The service had eight staff vacancies when we inspected and were working two staff short on the day shift during the inspection. The registered manager informed us in the week following the inspection that all vacancies had been recruited to.

Agency staff were used to cover shifts on the rota but the day of our inspection two agency staff did not turn up for duty. The registered provider had preferred agencies that they liked their managers to use, but we saw that these were not reliable as staff did not always turn up for duty as booked. We saw evidence that recruitment checks had been carried out for the agency staff and each member of the agency staff had received an induction to the service. There was a dependency tool in use, but we saw no evidence of how this linked to staffing numbers. The district manager told us they looked at the tool each time they visited but there was no documentation about this.

We observed the daily routines of the service and saw there were times when the lack of staff put people at risk of harm. For example, we saw that the medicine rounds took a long time to complete and we noted that one person received their morning medicines at 10:45am which meant medicines were not being given as prescribed. Also after the lunch time meal on one of the units the member of staff supported somebody with personal care. Whilst they were away, we saw one person who used the service approach another person who was still seated at the dining table and poke them in the back. The person who was poked, told the person to go away and although this did not escalate this highlighted the potential for situations to escalate whilst staff were not present.

We fed back our concerns about the levels of staff to the district manager and the registered manager at the end of our inspection. We were informed in October 2016 that the registered provider had agreed for an

extra member of staff on each floor from 08:00am to 14:00am and additional staff were being recruited. Due to the prompt action taken by the registered provider we have not made a requirement in this report.

We recommend that the service considers current guidance on use of a dependency tool linked to staffing levels to monitor the requirements of people using the service and takes action to adjust staffing levels accordingly when people's needs change.

We looked at the maintenance records and found that the electrical installation survey carried out in August 2016 found the wiring to be unsatisfactory. We asked the district manager what action had been taken by the registered provider to ensure the wiring was safe. We were told that repairs would take place within three months of the report being received and we received email confirmation that work was starting at the beginning of October 2016.

We saw that health and safety risk assessments for the environment and equipment were in place, but these needed reviewing as they were last done in 2015. The registered manager said they would do these straight away. The fire risk assessment was dated March 2016 and had a number of recommendations and requirements on it. The maintenance person had completed all those that fell within their remit, but others remained outstanding. The district manager said that a new contracting company would be coming out to complete any outstanding actions the week commencing 10 October 2016.

Regular weekly and monthly checks were carried out by the maintenance person. We saw that they had reported some faults to the emergency lights which had yet to be repaired. Following our inspection we were notified that the repairs would be dealt with on 29 September 2016. The maintenance person had a repairs book where staff recorded any small jobs that needed attention. These were dealt with quickly and effectively. We found the book was up to date and signed off once each job was completed.

We discussed with the district manager and the registered manager at the end of the inspection the need to ensure maintenance and repairs were carried out quickly and effectively where issues were identified through audits, health and safety checks and risk assessments. On 24 October 2016 we were contacted by the district manager to confirm that all the above repairs and contracting work had been completed. For this reason we have not made a requirement in this report.

The registered manager showed us the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. The plan had been reviewed in May 2016. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were kept in the nurse's office and were up to date. Fire drills were completed with the staff and the last one was held in February 2016.

The registered provider had policies and procedures in place to guide staff in safeguarding adults. The registered manager described the local authority safeguarding procedures and our checks of the safeguarding file showed that there had been eight alerts raised by the registered manager in the last twelve months. We received feedback from the local authority safeguarding team that they had no on-going concerns about the service and the information we hold about the service showed that CQC had been notified of all of the alerts. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke to staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to either the senior member of staff on shift, or the registered manager. One member of staff told us, "I would report any concerns I had and would take it higher if I needed to. I know I can report things anonymously if I want to and whistle-blow." Another said, "If I had any concerns I would speak the manager, they are really approachable which helps." The staff told us that they had completed safeguarding training in the last year and the training records confirmed this.

We looked at the recruitment files of four members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

Care files contained risk assessments that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered by the staff and recorded correctly and disposed of appropriately. The senior care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files.

We asked if people understood what their medicines were for and one person said, "I am not really interested as the staff deal with this for me and they bring my medicines to me at the same time each day. I put on my own cream each day." Another person said, "Usually I get my morning medicine at around 10:30am. I would like it a 09:00am." The issue about late administration of medicines was discussed with the registered manager when we spoke about the staffing levels.

The medication room keys were held by the senior care staff on each floor. Controlled drugs (CDs) were regularly assessed and stocks recorded accurately. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature.

The senior staff were able to tell us about how they returned unused and unwanted medicines to the pharmacy supplier. There was a return medicines book in place and a cupboard for returns medicines, which were picked up by the pharmacy within 72 hours of the staff calling them for a collection.

Good

Is the service effective?

Our findings

We asked people who used the service if they felt the staff were sufficiently skilled and experienced to care and support them to have a good quality of life. All of them said "Yes." One person told us, "The staff understand me and I like that." One visitor to the service told us, "Staff skills seem okay and they interact well with people."

We found that where staff had identified a person demonstrated aggressive behaviour at times, they had conducted an assessment to identify triggers to this. For example, we observed one person using the service became very anxious, shouting loudly and repeating the same name over and over again. We discussed this with the staff who told us that [Name] could be both physically and verbally aggressive. In the past [Name] had physical altercations with other people who used the service and staff. We looked at their care plan and saw that their distressed behaviour had been identified and an individual behaviour plan was in place. The plan instructed staff to remove the trigger or the individual from the situation, such as encouraging the person to sit in their bedroom where it was quiet (as advised by the Community Psychiatric Nurse). The staff told us, "We don't use restraint here, we just try and stay calm and ask [Name] to leave the room. Sometimes it works, sometimes it doesn't."

Staff told us that they had not received any training on managing distressed or agitated behaviour and that they felt this would be of benefit to them, by increasing their skills and knowledge of how to de-escalate incidents in the service.

We recommend that the service provides training for the staff, based on current good practice, in relation to the specialist needs of people living with dementia.

We looked at induction and training records for four members of staff. These indicated that new staff received training and monitoring of their practice, to ensure they could provide safe care and treatment. We saw documentation that indicated new staff shadowed more senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these competencies were signed off on their induction paperwork. One staff member said, "Yes, I had an induction. I had two weeks training and it was quite intensive. The training we completed goes toward the National Vocational Qualification (NVQ) [now known as a diploma in Health and Social Care] so it was really worthwhile. We get a pay rise when the NVQ is completed so I am hoping to achieve that soon."

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity.

We looked at four staff supervision records, which showed that care staff were being supervised by the

senior care staff. The staff we spoke with were positive about their supervisions saying, "I have regular supervision, I find it useful and I generally receive positive feedback", "I've not worked here long, but I have had an initial supervision" and "I have supervision every three months. It's a two way conversation and I find they are constructive."

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that five people who used the service had a DoLS authorisation in place around restricting their freedom of movement and these were kept under review. Applications had also been submitted where needed for other people and the registered manager was awaiting the outcome from the authorised supervisory body.

The care records we saw reflected a general understanding of the principles and requirements of the MCA and DoLS and staff who spoke with us demonstrated a general awareness of the concept of MCA and DoLS. Staff told us, "If a person does not have capacity then some decisions could be taken for them after a best interests meeting. Day to day life decisions can still be their own. You can involve a person's GP or community psychiatric nurse (CPN) if their mental health needs are deteriorating. You would always assume capacity and offer daily life choices."

People were able to talk to health care professionals about their care and treatment. All individual health needs, visits or meetings were recorded in the person's care file, with the outcome for the person and any action taken (as required). We asked people who used the service what happened if they did not feel well and they told us, "The staff are lovely, they would arrange for us to see our GP or the district nurse straight away." People also told us that they had visits from a chiropodist and an optician.

We saw that the registered manager monitored people's health and well-being through observation of staff practice and auditing of the service. The skin integrity audit of August 2016 showed that three people had superficial pressure sores, which were being looked after by the district nursing team. Twelve people had some weight loss noted and had visits from their GPs arranged. We found that nutritional care plans were in place for these people.

We spoke with one visitor who told us the staff were very good at calling out the GP for their relative when needed and said, "[Name] has been seen by the dietician and the SALT team." They told us there was good communication with the staff and the staff spoke to them every time they visited and updated them with how their relative was doing. They told us they had seen the staff using the hoist with their relative and they were confident they had the skills to care for them effectively and efficiently.

At breakfast time people were able to choose from a variety of cereals, toast and crumpets. A full English

breakfast was also offered every day. One person who used the service told us, "The food is fine, you get a good breakfast. They have cereals, fruit, bacon, sausages and eggs." We saw in one person's care plan that they preferred to have toast and jam at breakfast time and we saw that this was what staff had prepared for them.

We observed the serving of lunch in the dining rooms on two of the floors where people were living with dementia. Tables were set with tablecloths, tablemats and cutlery. Most people chose to eat their meal in the dining room whilst others chose to have their lunch in the lounge. We saw that one person was provided with an apron to protect their clothing from any food spillages.

Meals were delivered to each dining room in a 'bain-marie' to ensure that the food was served hot. Lunch consisted of two courses and on the day of the inspection a choice of two hot meals was on offer. If people did not want either of the options then an alternative was offered. People were also offered a choice of hot and cold drinks. Meals were served to people one at a time by a member of care staff and this enabled each person to choose which meal they would like at the time it was served. When people were unsure what meal to choose, meals were plated up and shown to the person so they could see the choices before making a decision. We saw that one person was still unable to choose so the member of staff gave them a small sample of each meal to try. This meant that even when people were unable to effectively communicate what they wanted they were still offered a choice.

Although we did not observe anybody that required assistance with eating a number of people required prompts, reassurance and the encouragement of staff to remain at their table and finish their meal to ensure they had enough to eat and drink. However, as there was only one member of staff available to support them this meant that they were over-stretched to ensure that everybody had their needs met. For example, one person knocked their plate off the table and this meant the member of staff had to stop what they were doing and ensure that the floor was clean and dry to prevent any slip hazards. We gave feedback at the end of the inspection to the registered manager about the levels of staffing and the impact it had on people.

We spent time talking with the chef. They explained they were aware of people's special dietary needs and could identify people who required a soft/blended diet, a diabetic diet or an enriched diet. Information was sent to the chef directly from the dietician or following a hospital admission advising them of any dietary changes that were required. The chef told us, "If anybody is at risk of losing weight then the seniors inform me. I update the board so all kitchen staff are aware and we will make sure that their meals are supplemented with additional calories by adding cream, butter and also making up milkshakes." The chef told us that they would not make any changes to people's diet unless they had been notified by a specialist. They said, "I won't put people on a soft diet unless I receive advice from a specialist. I don't want to take away people's ability to eat a normal diet unless it's been assessed as a necessity."

People were weighed on a regular basis and if any weight loss was identified, we saw that appropriate action was taken. For example, staff had noted that one person who was assessed as being at a high risk of malnutrition had lost a small amount of weight over a two-month period. The service had contacted the GP who had advised the staff to continue to follow the current dietary advice that had been provided by the dietician and ensure that weekly weights were taken. During our inspection we noted that milky drinks and high calorie snacks were offered to people identified as being at nutritional risk.

The service was well presented and provided a clean and homely environment for the people living there to enjoy. We saw that some aspects of the service had been designed to create a dementia friendly environment. The dining rooms had signs on the doors to inform people where they were located and toilet

doors had bright yellow signs on them to help people easily distinguish between the toilet and other rooms. We saw that toilets had contrasting coloured toilet seats and grab rails. Contrasting colours can help people living with dementia to more easily identify where the toilet is and locate handrails, which can reduce the risk of falls. We also saw contrasting coloured handrails were used in the corridors and this encouraged people to use them, again reducing the risk of falls. Plain carpets can aid people with perceptual problems to move around their environment more easily and we saw that these were used throughout the service. On the second floor we observed one person using a twiddle muff. Twiddle muffs are a knitted muff with items attached so people with dementia have something to occupy their hands and the muffs provide a source of visual, tactile and sensory stimulation.

There were some aspects of the environment that needed improving and the housekeeping audit from August 2016 highlighted the need for new carpets in the lounges and new armchairs/dining room chairs. The registered manager had sent in a request to the registered provider for these in August 2016. Observation of the lounge carpets showed that these were not fitted correctly and had bumps/ridges in them that were a trip hazard to people walking in these areas. We saw that dining chairs in the dementia side of the service needed replacing. The plastic top layer and wipe clean element of the chairs had deteriorated and the soft fabric underneath was exposed.

We saw that there was a record of on-going maintenance and repair that showed the registered provider was committed to ensuring the service remained safe and any health and safety issues were monitored and addressed. Following the inspection we were notified that the carpets had been replaced. For this reason we have not made a requirement about the environment in this report.

Good

Is the service caring?

Our findings

We received very positive feedback about care staff and their support for people. Comments we received from relatives and people using the service included, "Aye, the staff are all okay, they're always good with me", "I have no concerns about [Name's] care as the staff are absolutely brilliant" and "The staff have asked me about my care. They have made my room more homely by adding photographs and other items."

We observed staff interacting with people in a manner appropriate to each person. Staff knew people's needs and were quick to respond when they showed signs of distress. For example, we saw one person who used the service displayed some anxious and distressed behaviour. Staff quickly and calmly approached the person and spoke with them in a reassuring manner, and distracted them by supporting them to return to their dining table in preparation for their lunchtime meal. A member of staff said, "I have really worked at getting to know people, I looked at people's likes and dislikes in their care plan and feel it is starting to pay off. I can recognise when people are getting agitated and I try and distract them before it escalates."

All of the actions observed by staff were positive, however as they were often working alone they did not have the time to stop and chat to people as they would have liked. For example, we saw that when a person required support to go to the toilet this meant that other people were left unsupervised for as long as the care intervention lasted. One member of staff told us, "I just want to have the time to care for people as I would like to be cared for and when I am by myself I can't. If somebody needs personal care it could take me 10 minutes and this means everybody else is left by themselves for this time. What if they fall? It's really stressful." We spoke with the district manager and registered manager about our concerns over the staffing levels at the end of the inspection. The registered provider acted quickly following our inspection to improve the numbers of staff in the service.

People were treated with dignity and respect. The staff's approach was professional, but friendly and caring. Staff spoke with people in a polite and respectful way and showed an interest in what people wanted to say to them. Staff called people by their preferred name, knocked on people's doors before entering and ensured they had privacy whilst they carried out their personal care. One member of staff told us, "I always try and treat people how they would want to be cared for. In a morning I leave the curtains closed until they are washed and ready for the day. I would never do any personal care anywhere other than in the toilet or their bedrooms."

Staff explained how they tried to promote people's independence and encouraged them to maintain their life skills. One staff member said, "[Name] will still try and do some things for themselves, like getting dressed in the morning. I let them get on with it and if they put something on the wrong way I help them put it right." We observed a member of staff supporting a person to stand from their chair. The member of staff talked the person through the manoeuvre and encouraged them to use their own strength to move from sitting to standing whilst providing minimal amount of support. Although this took longer, it enabled the person to recognise what they were still capable of.

We saw that the bedrooms were fitted with shower and toilet en-suite facilities and people told us they were

able to have a shower or bath whenever they wished to have one. People said, "I have my own shower and can have one when I like" and "The staff are very helpful." As we walked around the building in the morning we saw that people were being assisted to get up, washed and dressed at their own pace. People were well presented and dressed appropriately for the weather.

One relative told us their only concern about the service was a very minor one and was in relation to the laundry service. However, they stressed to us that their relative using the service was always well presented and said, "The staff really care, oh yes they do – you can tell."

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. Staff also supported people to maintain relationships with family, friends and other people in the community.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager. People told us they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for themselves or had a member of their family who acted in this capacity for them. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Good

Is the service responsive?

Our findings

People who used the service and relatives were very positive about the service and the staff. It was compared to a five star hotel on more than one occasion when we spoke with people, and no-one said they were unhappy or wished to be elsewhere. Staff were knowledgeable about the people they supported. They were aware of people's preferences and interests, as well as their health and support needs, which enabled them to provide personalised care to each individual.

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. We looked in detail at seven of these files. The information recorded was detailed and person centred. Records evidenced that the information had been gathered from the person themselves and/or their family. One file had dementia records such as a 'Life story' covering 'all about my life', 'my life now' and 'my life going forward'. These records gave staff an insight into the wishes, choices and needs of the person using the service, which helped them give care and support in line with the wishes of the person.

Not everyone who used the service was sure if they had seen their care plans or had input to them. However, we saw that people and families were invited to yearly reviews of their care plans and those who spoke with us were unanimous in the view that things were okay in the service and staff did change their care practices to match circumstances such as deteriorating health or mobility. One person told us, "I get the care I want and it meets my needs. For example, tomorrow I have a hospital appointment and my family are taking me to the hospital." One relative told us, "I can pick up [Name's] care file and read it whenever I wish, and I have been asked by the staff to contribute to their life history and read/sign their care plans." This relative had Power of Attorney for their family member's health and wellbeing.

The notice board on the ground floor had an activity planner on it. This showed there were regular events each day such as, exercises on a Friday, cake baking on Wednesdays and Saturday theme nights. One person told us, "You know what is going on by what is on the notice board. I have been on two barge trips, but I like a bit more to do to occupy myself. This morning for example, I helped staff by clearing the dining tables."

We did not see any real evidence of activities taking place during our inspection and from our observations of the service and feedback from staff we concluded this was due to the low staffing levels. There were books, jigsaws and puzzles for people to complete and soft toys and the odd twiddle muff in the lounges but the main activity seemed to be the television. This was on from the time we arrived at the service until we left, and was not turned off at lunchtime. Some people did watch this but the vast majority were not paying it any attention. Some people did spend time in their own rooms and they were able to watch their own televisions, listen to the radio and read a book. One relative said, "[Name] used to take part in activities, but is no longer able to." The staff said, "We encourage friendships where we can. We push the tables together in the afternoon and have tea and biscuits. Some people enjoy doing things as a group, others don't."

We were shown a copy of the activity planner and found that each month there was one main entertainment

booked such as a singer in October 2016. Other activities in August 2016 included a trip to Blackpool, a cornflake cake and tray bake evening, a popcorn and movie night and a sing-a-long with an entertainer. In September 2016 people enjoyed a pie and pint evening, cakes and shakes session, pancake and Cornish cream tea and a cake decorating activity. Two Bistro rooms opened in the service in September 2016 with a rock and roll theme and the registered manager said these were well received by people and families as places to sit, chat and enjoy a change in environment.

People said they received regular visitors who were always made welcome by the staff. One person told us, "I go out with my family on a regular basis" and another person said, "I can't go out by myself, they think I'm a bit daft and that I might get lost. It's okay though as my daughter takes me out."

There was a complaints policy and procedure on display on the notice boards in each unit. This described what people could do if they were unhappy with any aspect of their care. The policy and procedure needed updating to show the registered provider details. This would help people have the right information should they wish to take their concerns higher than the registered manager.

We looked at the complaints file kept in the service and found that four complaints had been received in 2016. These were minor issues around lost laundry and care practices and the registered manager had responded to each person making the complaint and these were now resolved. Over the same time span the service had received five compliments about the staff and their love, care, patience and compassion towards people who had used the service.

One visitor said they were aware of the complaints procedure and they had used this when they had concerns about their relative falling out of bed. They went on to say that the registered manager had listened to their concerns and their relative had been provided with a 'rise and fall' bed, which reduced their risk of falls. People understood how to make a complaint. One person said, "My family would speak up for me as I am too soft. However, I am not unhappy about anything."

Requires Improvement

Is the service well-led?

Our findings

We saw that the registered manager monitored and analysed risks within the service and reported on these to the registered provider. However, there remained some areas of the service that could be improved. These included health and safety/maintenance, some aspects of the environment and staffing levels. We saw that low staffing levels impacted on the ability of staff to carry out activities and care duties and that maintenance and environment issues were not dealt with promptly, which potentially put people at risk of harm.

We gave the district manager and registered manager feedback about our concerns at the end of our inspection. These issues had been identified through the quality monitoring and assessment process carried out by the registered manager and should have been acted on and dealt with immediately by the registered provider to ensure people's needs were met and health and safety maintained. Following our inspection the registered provider acted quickly on the issues raised and made improvements to the service and staffing numbers, which has resulted in us only making recommendations in other sections of this report.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open and transparent and the registered manager sought ideas and suggestions on how care and practice could be improved.

We sent the registered provider a provider information return (PIR) that required completion and return to CQC by April 2016. This was completed and returned within the given timescales. The information in the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

There was a registered manager in post who was supported by a deputy manager and senior care staff. The majority of people who spoke with us were able to tell us the name of the registered manager and were confident about raising any issues with them. One person told us, "I cannot remember the manager's name, but I know who they are and would not think twice about speaking to them if I had any issues." People told us they felt the service was well run and said they were happy there.

Staff spoke positively of the service. Comments included, "When I compare this home to others that I have worked in, I feel it is really well organised. There is a really nice staff group." Another said, "I love it here." Staff also spoke positively of the registered manager. Comments included, "I get on well with the manager, they are really approachable." Another said, "I can go to the manager and deputy manager with anything, they are really supportive."

People told us that meetings were held regularly and that they were asked if they wanted anything to go on the agenda. We saw that a residents' meeting took place in August 2016 when they discussed menus, new

staff and activities. There were feedback sheets in the form of 'You said/We did' forms and saw that previous issues discussed had been cold food, short staffing and supper arriving late.

We saw other ways that the registered manager used to obtain people's views of the service. This included satisfaction questionnaires which were sent out in February to April 2016. The surveys were sent out monthly about different topics and there was an analysis of the results, but no action plans. We queried who was filling out the surveys, given that so many of the people using the service were living with dementia, and the registered manager said families did this where the person was unable to. One person told us they didn't think they had taken part in the resident meetings, but they said, "I have a good relationship with the staff and could talk to them about anything. I feel that I am kept informed of what is happening in the home and I can look at the notice board for any upcoming events."

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 The registered provider failed to monitor risks relating to the health and safety of people using the service. Regulation 17 (1) (2) (a) (b)