Kargini Care Services Limited

Grasmere Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 20 July 2016 and was unannounced. Grasmere Nursing Home provides accommodation, nursing and personal care for up to 21 older people or people with a physical disability. The service offers long term and respite care. At the time of inspection there were 19 people living at the service. People were mostly older with complex needs or physical frailty requiring personal care and nursing support with all activities of daily living. Accommodation is provided in an older building over three floors with a mezzanine area on the first floor. There are 20 single bedrooms, several of which have en-suite facilities. All rooms on the first and second floors can be accessed by a passenger lift. The mezzanine area can be accessed by a platform lift and there are stair lifts located on several staircases around the home. There are landscaped gardens to the front of the building and a small patio to the side for resident use. The service is located in a residential area, located a short distance from shops, public transport, local amenities and the seafront.

The registered manager had been in post since October 2015 and was present 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.

People received their regular medications safely and as prescribed. However, stock balances were not maintained, so any discrepancies could not be identified and homely remedies had not always been recorded, so it was unclear if people had received them or not. Allergies were not recorded accurately on the medication administration record for two people, which meant they were at risk of being prescribed and administered medicines which could cause them harm. There was also a lack of guidance for staff regarding the administration of 'as required' medicines, which meant that there was a risk of medicines being given inappropriately. Dates of opening were not always recorded on liquid medications which had a limited shelf life, which meant that people were at risk of receiving out of date medicines. This meant that medicines were not always managed safely and was identified as a breach of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks were identified and assessed. However, guidance for staff lacked sufficient detail to manage these risks effectively. For example, one person had difficulty swallowing liquids. A Speech and Language Therapist (SALT) assessment recommended that one scoop of thickening agent per beaker would thicken fluids sufficiently for the person to swallow them safely. However this information was not incorporated into the care plan for this person. Another person was identified as prone to constipation. There was a stool chart in place and they were prescribed 'as required' laxatives. However, there was no clear guidance to staff regarding this person's usual routine or when 'as required' medicines should be given. This meant that staff did not have all the information they needed to manage individual risks effectively and was identified as an area of practice that needs improvement.

Staff had received training and understood the principles of the Mental Capacity Act 2005 (MCA). There were detailed mental capacity assessments in place and where people lacked mental capacity to make some decisions there was clear guidance to staff regarding which decisions people could make for themselves and which they could not. However, where people were assessed as not having capacity it was not clear how or why decisions had been made on their behalf. This meant that decisions made in people's best interests were not recorded in line with legal requirements and this was identified as an area that needs improvement.

On the day of inspection the dining room was shared with the hairdresser whose kit remained laid out over the lunchtime period. The registered manager told us this happened once a fortnight. One person was part way through having their hair done when lunch was served. This was not dignified experience for this person, nor was it hygienic or pleasant for others eating in the dining room, as there was also a strong smell of perming lotion and we have identified this as an area of practice that needs improvement.

The provider employed dedicated activities staff and there was a programme of activities and entertainment in place. Art and craft activities were held twice a week and entertainment and exercise sessions also took place. One member of staff was employed to deliver one to one activities to people who were at risk of social isolation and they told us how they spent time with people reminiscing or reading the newspaper. There was a garden party in June which was well attended and people were invited to plan further activities through discussion in residents meetings.

People told us they felt safe and that there were enough suitable staff to meet their needs. Call bells were answered promptly. One person said, "Oh yes, they always come very quickly and check what you need them to do for you." There was a robust recruitment process in place to ensure that any staff employed were of good character and safe to work with people.

Environmental risks were well managed. There were health and safety and equipment checks in place and any repairs were attended to promptly. Accidents and incidents were recorded and monitored for trends with actions plans in place to reduce the risk of recurrence.

People were appreciative of their environment, they told us it was clean and they liked the décor.The environment was clean and well maintained with no malodours. Cleaning schedules were in place and waste was managed appropriately. There was an infection control champion and staff were trained in infection control and used personal protective equipment such as gloves and aprons appropriately.

Staff had the knowledge and skills to support people's needs and were supported through regular supervision and appraisal with the registered manager. People told us they felt that staff were well trained and knew what they were doing.

People were supported to have sufficient to eat and drink. Special or modified diets were provided and people said that they enjoyed the food. Hot and cold drinks were offered throughout the day and fluid intake was monitored for those identified as at risk of dehydration or urinary tract infections.

Staff monitored people's health and wellbeing and supported people to access health care services such as chiropody, optical and dental services. One person told us, "They are having my eyes seen to." A health care professional working regularly with the service told us that staff made timely and appropriate GP referrals and recognised when an urgent referral might be required. One person said, "They noticed my swollen foot and it's going to get looked at."

One person said, "The staff are great and anyone would be happy here." The atmosphere of the service was warm and friendly and there were smiles and laughter between people and staff throughout the day. Relatives and visitors to the service told us they were always made to feel welcome.

People felt listened to and that their opinions mattered. A residents survey was undertaken in February 2016 and there was an action plan in place to address any issues raised. Minutes from regular residents meetings demonstrated that any actions taken as a result of the survey had been effective. Residents were consulted and included in the running of the service and felt that it was their home.

Staff had received training in dignity and respect. They understood how to protect people's privacy and spoke with them about their care in a respectful manner. Relatives and visitors were made to feel welcome. A visiting health care professional told us how staff were prepared for their visit and always offered them a hot drink. A relative thanked staff at a residents meeting in July, 'For all the cups of tea they make.'

People received personalised care that was responsive to their needs. People had signed their care plans and individual records contained detailed life histories and lifestyle preferences. For example, one person's record stated that they preferred to take their meals in their room. Staff knew people well and found ways to support people as individuals. For example, one person was hard of hearing, so staff used a wipe clean board to write down what they were saying if the person was finding it difficult to understand them.

People and staff had confidence in the registered manager who was visible and approachable. The registered manager demonstrated good oversight of the service and understood the needs of people well. They had an inclusive and consultative approach to decision making and actively sought feedback from people, staff and relatives in order to improve the quality of the service.

There was a quality assurance system in place to inform and drive improvements to the service. Infection control and care plan audits had been undertaken and any associated action plans were in progress or completed. Staff were kept up to date with audit outcomes and improvement plans in regular staff meetings.

We identified a 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 the 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 always safe.

Medicines were not always managed safely and there was a lack of guidance for staff regarding the administration of 'as required' medicines.

Individual risks were identified; however guidance for staff lacked sufficient detail to manage risks effectively and safely.

The provider used safe recruitment practices and there were sufficient skilled staff employed to meet people's needs.

Staff were trained in safeguarding adults and understood their responsibilities with regard to keeping people safe from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessment were detailed and supported people to make day to day decisions, however there was a lack of underpinning evidence to support decisions made in people's best interest.

People were supported to have sufficient to eat and drink, but the dining environment was not always acceptable.

Staff had the skills and knowledge to meet people's needs. They were supported through regular supervision and appraisal.

People's health and wellbeing was monitored any referrals to health care professionals were appropriate and timely.

Is the service caring?

Good

The service was caring.

Staff supported people cheerfully and with genuine warmth. People told us the service was friendly and welcoming.

People were included in decision making and planning

improvements to the service. Their opinions were valued and acted upon.

People were supported respectfully and with dignity.

Is the service responsive?

Good

The service was responsive.

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

Individual plans were signed by people to demonstrate their involvement and contained detailed life histories and lifestyle preferences.

There were dedicated activities staff and an activities programme in place.

There was a complaints procedure in place and any concerns were responded to in a timely and appropriate manner.

Is the service well-led?

Good

The service was well-led.

People and their relative had confidence in the registered manager and staff, and healthcare professionals felt that the home was well organised.

There were quality systems in place to monitor the quality of the service and identify areas for improvement.

The registered manager actively sought feedback from people, staff and relatives in order to understand and improve on their experiences.

Grasmere Nursing 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. The service was previously inspected on 18 September 2014 and no concerns were identified.

The inspection took place on 20 July 2016 and was unannounced. The inspection team consisted of an inspector and an expert-by-experience in the care of older people and people living with dementia. 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 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted stakeholders, including health and social care professionals involved in the service for their feedback. Two health and social care professionals gave feedback regarding the service and one gave their consent for their comments to be included in this report.

During the inspection we observed the support that people received in the lounge dining and communal areas and where invited, in their individual rooms. We spoke to seven people who lived at the service, six members of staff and one relative.

We reviewed four staff files, three medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records and surveys undertaken by the service. We also looked at the menu and activity plans. We looked at care records related to five people; these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and that there were enough staff to meet their needs. One person told us, "Oh yes, they always come very quickly and check what you need them to do for you." However, despite the positive feedback, we identified areas that were not always safe and require improvement.

People received their regular medicines as prescribed. There was sufficient medication in stock, however, stock balances were not maintained which meant that any discrepancy or error in the administration of medication would be difficult to identify. Homely remedies are over the counter medicines such as simple pain killers that are used to treat people with minor illness, such as an occasional headache. A bottle of simple linctus was open and some of the medicine had been used. However, there was no record of who had received the simple linctus, when or what dose. Failure to record the administration of homely remedies could put people at risk of receiving duplicate doses of over the counter medicines. Medicines can be less effective or harmful if they are out of date. Some liquid medicines have a limited shelf life once they are opened, as they can become less effective over time. For example, two bottles of liquid medicines held as homely remedies were open but did not have the dates of opening recorded. People's records detailed any medication allergies; however these had not been accurately entered on the medication administration record for two people. For example one person's individual record showed that they were allergic to three different medicines, but their medication administration record stated that that no allergies were known. This meant that there was a risk that they could be prescribed and administered a medicine to which they were allergic. Some people were prescribed, 'as required' medicines. 'As required' medicines are meant to be taken occasionally when there is a specific need, for example, tablets for pain. Two people with 'as required' medications did not have information in place to ensure that these medicines were given consistently and in accordance with prescribed instructions. The prescription had changed regarding the dose of an 'as required' medicine for one person, but the instructions to staff on the medication administration record had not been altered to reflect this change. Staff knew people well and were able to explain what each medication was for and when it should be given, but without clear guidance to staff there is a risk that 'as required' medicines could be given inconsistently or not in accordance with prescribing instructions. This meant that the management of medicines was not always safe and this was identified as a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Topical medicines were stored separately from oral medicines and the medicines fridge was clean with evidence that it had been defrosted regularly. Room and fridge temperatures were monitored daily to ensure that medicines were stored correctly. People were supported to self-medicate where appropriate. One person administered their own inhaler and their care plan had a risk assessment in place to support this.

The administration of medicines was person centred. Medicines were administered by nurses and we observed a nurse giving medicines to people at lunch time. They addressed people as individuals and knelt beside or in front of them to give them their medicines. The nurse asked people if they had any pain and told them what their medicines were for. The nurse asked one person, "Would you like some paracetamol for the pain in your knee?" They checked with another person that they had managed to swallow their tablet by

asking, "Has it gone?" One person was prescribed eye drops but the nurse told us that she would administer these after lunch as the person was in the lounge area about to eat their meal. Inhalers were also not administered while people were eating, but were left until after lunch, so as not to spoil people's enjoyment of their meal.

There was a medication audit in March 2016 and fortnightly spot checks of the medication administration records to ensure that people were receiving their medicines correctly. The registered manager undertook medication competency checks with the nurses as part of their annual appraisal and these were documented. On the afternoon of the inspection the pharmacy working with the service arrived to undertake an audit of medication practice. The audit had been requested by the registered manager as part of their quality assurance programme. The registered manager shared our findings with the pharmacist undertaking the audit and told us that she would also feedback to the nurses over the next few days.

People's individual risks had been identified, however care plans did not always contain sufficient details for staff to manage individual risks and keep people safe from harm. For example, one person was assessed as being prone to constipation. There was a stool chart in place to monitor this and they had been prescribed a laxative to be given 'as required.' However, the care plan did not give sufficient guidance to staff regarding the person's usual routine and under what circumstances staff should consider the administration of a laxative. Another person was identified as having swallowing difficulties. A Speech and Language Therapist (SALT) had assessed the person and recommended thickened fluids in order to manage the risk of choking and chest infections due to the inhalation of liquids. The lack of detailed guidance to manage individual risk has been identified as an area of practice that needs improvement.

Staff were aware of their responsibilities in relation to keeping people safe. Staff had received training in safeguarding people and were able to describe the different types of abuse and what action they would take if they suspected abuse had taken place. There was a safeguarding policy and a whistleblowing policy in place. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation or directly to external organisations. Information about safeguarding people displayed on notice boards and a copy of the local authority policy and procedures for safeguarding was available for staff in the main office.

Risks associated with the safety of the environment and equipment were identified and managed appropriately to include temporary risks. For example, there was a risk assessment completed when the lounge had been redecorated. There was an emergency plan in place and equipment, such as lifting equipment, had been checked and serviced regularly to ensure it was safe to use. The fire alarm system and equipment were checked at regular intervals. There were personal emergency evacuation plans in place for people living at the service and regular fire drills had taken place. Two members of staff told us that there had been a fire drill two days prior to the inspection and one member of staff described how they had been involved in a practice evacuation. Records of these drills were available in the fire folder. Accidents and incidents were reported and monitored with appropriate actions taken to reduce the risk of recurrence.

There were sufficient numbers of suitable staff on duty to meet people's needs and shifts were arranged to give staff time to handover effectively to each other. The registered manager used a dependency tool to calculate staffing levels, but said that in addition to the tool they would listen to staff and monitor people's needs to ensure that staffing levels were adequate. People told us and we observed that call bells were answered promptly. A member of staff told us that they liked working at the service because they, "Have time to spend with the residents."

Staff had been recruited through an effective recruitment process that helped ensure they were safe to work

with people at risk. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The service had obtained proof of identity, employment references and employment histories. Nurse registration and fitness to practice was also checked prior to employment to ensure that nurses employed were actively registered with the Nursing and Midwifery Council and able to practice without restrictions.

There was an infection control champion and staff had received training in infection control. The communal areas of the home and the bedrooms were cleaned every day and there were no malodours. One person said, "They work hard to keep the place clean." There were cleaning schedules in place and a member of staff told us that these were completed on a daily basis.

Requires Improvement

Is the service effective?

Our findings

People told us that they felt well looked after. One person said, "The staff are very obliging and know what to do for you." Another person told us, "They know what they're doing." However, despite the positive feedback, we identified areas that were not always effective and needed improvement.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training and understood the principles of the MCA. One member of staff told us how they supported people to make day to day decisions about what to eat or what to wear by chatting to them about the options and their preferences. There were mental capacity assessments in place and where people were assessed as lacking mental capacity the assessments listed which decisions they were able to make and which needed to be made in their best interests. However, where people were assessed as not having the capacity to consent it was not clear how or why decisions had been made on their behalf. This meant that decisions made in people's best interests were not recorded in line with legal requirements and this was identified as an area that needs improvement.

The registered manager had identified a three people who were subject to restrictions that deprived them of their liberties and had made appropriate applications to the local authority. Staff told us they explained the person's care to them and gained consent before carrying out care. A member of staff was heard asking a person, "Hello I've come to give you a wash if that's alright?" Throughout the inspection, we saw staff speaking clearly and gently and waiting for responses. One person had elected their brother to consent on their behalf as they found it difficult to write. They had signed the care plan once to give their permission and thereafter their brother had signed for them.

We observed people's lunch time experience in the lounge and dining areas. On the day of inspection the dining room was also being used by the hairdresser and the registered manager told us that this happens once a fortnight. One person was having their hair permed over the lunch time period and were sat in a wheelchair in the middle of the dining room on their own with a small side table in front of them. A person and their relative sat at another table against a wall. The hairdresser's kit occupied the other table in the room and there was a strong smell of perming lotion. The person and their relative were talking quietly together. Staff brought food and drink to people in the dining room, but did not actively engage with the

person sitting on their own. After a while a member of staff realised that the person sitting on their own was not eating and offered to help them by cutting up her food and asked them if they wanted a spoon. The dining experience for the person having their hair done was not dignified or enjoyable and this may have been reflected in how little they ate. For the person and their relative the smell of hair dressing products and sharing the dining room with the hairdresser's kit was not a positive experience. The hairdresser visits the service fortnightly and therefore this has been identified as an area in need of improvement.

The lunch time experience in the lounge for other people and those who ate in their bedrooms was positive. Five people were having their lunch in the lounge area. People were clearly enjoying their food which looked and smelt appetising. One person said, "This is beautiful I'm really enjoying this." People were served meals modified to a variety of different textures according to their needs and some people had plate guards in place to support them to eat independently. Staff checked that people were ok and enjoying their lunch. A member of staff collecting an empty plate from a person said, "Pudding is just on its' way, did you enjoy that?" A member of staff was supporting a person to eat. They sat next to them and chatted quietly as they assisted them to eat. They encouraged them gently asking if they were ready for their next mouthful.

Some people had chosen to have their meals in their rooms and this was documented in their care plans. One person's care plan stated that they preferred to take all of their meals in their room. Some people were independent, but others were in bed or needed support to eat. Staff helped people to sit up and checked their comfort. People were supported to eat with dignity and kindness. One member of staff asked a person, "Would you like me to help you I thought you might," and they both smiled at each other. People told us they enjoyed the food. One person told us, "The food is great." Another person said, "The food is extraordinarily good. You don't expect that but it is." There was a four week menu in place and the menu for the day was on display in the reception area. In addition to menu items people could request alternatives. There were kitchen cleaning schedules in place and a regular kitchen audit.

People were asked what they wanted to eat from the menu and offered alternatives if required. On the day of inspection one person had requested an alternative meal. The cook told us that this was not unusual for this person and provided the alternative meal, which was served at the same time as everyone else's lunch. Staff knew people and their preferences well. We heard one person say to a carer, "Oh good it's a little dinner that's much better otherwise it's such a waste." People said they were aware of meal choices and alternatives when asked about food in a resident's survey undertaken in February 2016. During lunch and throughout the day people were offered hot and cold drinks. One person told us, "I drink quite a lot particularly apple juice, so it's always here." The registered manager had reminded residents at a meeting in July 2016 to drink more during the hot weather and reminded staff throughout the day to encourage people to drink. It was a hot day and there were jugs of water and squash available in the lounge areas and within reach in people's rooms.

People's weights and food intake were monitored and fluid charts were in place to monitor fluid intake for people at risk of dehydration or those at risk of urinary tract infection. There were risk assessments in place for people at risk of malnutrition and a board in the kitchen displayed information for staff regarding people's allergies, food preferences and any special dietary requirements, for example a modified diet where food is pureed.

There was a training plan in place and staff told us that they had received essential training such as fire training and food hygiene. Training was delivered through workbooks followed by a written test which was externally verified to ensure that learning had taken place. A member of staff told us that they preferred to learn using the workbooks as they felt they retained their learning better as a result of having a written test. In addition to essential training staff could request additional training and spoke enthusiastically about

recent training in diabetes management recommended to them by the registered manager. A member of staff told us they had undertaken diabetes training in the past but that it was, "Good to remind yourself." Another member of staff was enthusiastic about what they had learned and were keen to share their knowledge of how to support people living with diabetes to eat healthily. Three members of staff described their induction which consisted of time spent with the registered manager and shadowing other members of the team. They described it as a combination of training and shadowing more experienced staff. Staff felt supported and met regularly with the registered manager for supervision and appraisals.

Staff monitored people's health and wellbeing and supported people to access health care services such as chiropody, optical and dental services. One person told us, "They are having my eyes seen to. It's next month I think." Another person said that they had seen the chiropodist the previous week. A health care professional working regularly with the service told us that staff made timely and appropriate GP referrals and recognised when an urgent referral might be required. One person said, "They noticed my swollen foot and it's going to get looked at." Another person told us, "They thought I needed to see a doctor, so they got one to me soon enough."

Good

Is the service caring?

Our findings

Staff supported people with genuine warmth and affection. One person told us, "I'm very lucky, I liked it from when my son first brought me to show me round. I wanted to join; it was such a friendly atmosphere." Staff were cheerful and approachable, a person told us, "They (staff) chat to you about all different things."

Positive relationships had formed between staff and people and there were smiles and laughter throughout the day. One person said, pointing to a carer, "This one here she is one of the best." Staff reassured and spoke with people in a kind, calm manner kneeling or sitting next to them when they spoke in order to maintain good eye contact. Staff often placed an arm gently around people's shoulders whilst talking to them, or took their hand and people were comfortable with this and responded positively. Two members of staff were supporting a person to move using a hoist. They explained what they were doing and checked how the person was throughout the procedure.

When we arrived at the service the registered manager introduced us to people living at the service. She was friendly and reassuring and explained to people who we were and why we were visiting. People responded positively and spoke highly of the registered manager and there was an atmosphere of mutual respect between the registered manager and the people in their care. A member of staff described the service as homely. They said, "It's their home it's where they live." People felt at home and a part of the service. Staff told us how one person had put their birthday cards up in the lounge and they had encouraged others to do so if they wished.

Staff had received training in dignity and respect and understood how to protect people's privacy. Personal care was carried out behind closed doors in the privacy of people's own bedrooms. Staff knocked and waited for permission before entering people bedrooms and used people's preferred form of address. A member of staff told us how they always made sure to close the curtains when giving someone personal care, and another told us how they spoke quietly and discreetly to people about their support when in communal areas.

People were supported to receive visitors and relatives were included in events at the service such as residents meetings. At a residents meeting in July one relative offered her appreciation to staff for all the cups of tea they make and one person's relative joined them for lunch two or three times every week. A health care professional who visited the service frequently told us that they were always offered a hot drink and made to feel welcome.

People told us they felt listened to. There were quarterly residents meetings and a residents survey had been undertaken in February. The survey indicated that not all residents felt that they could choose what time they got up in the morning. This was discussed with staff and monitored by the registered manager who followed this up with people at a resident's meeting in July. At the meeting people said they did feel that they had a choice of when to get up and when to go to bed which meant that actions taken following the residents survey had been effective. Minutes from residents meetings were available in the lounge area for people and their relatives to read.

Good

Is the service responsive?

Our findings

Staff knew people well and care was personalised and responsive to people's needs. Staff responded promptly and appropriately to people's requests for assistance and checked on people constantly to ensure that they had everything they needed and were comfortable. One person said, "I told them my room was ever so hot and it was affecting my breathing and straight away they went to get me that fan which has made a big difference to me." Another person told us that they used a beaker because they worried about spilling their drink, but that staff took the lid off for them when she wanted to dunk a biscuit.

Care planning was person centred and staff actively looked for ways to support people as individuals. For example, one person had difficulties using cutlery. Staff told us and their care plan stated that they found a plastic spoon lighter and easier to use, so they were provided with one at mealtimes. One person was hard of hearing. A member of staff showed us the wipe clean board that they used to communicate with them if they were having difficulty understanding what they were saying.

Care plans contained life histories and lifestyle preferences which included where people wanted to take their meals and what time they preferred to get up in the morning or retire at night. However, on the day of inspection people told us that this was not always the case. One person said, "I wake up about six o'clock. Sometimes I have to wait to get up. I think today was a couple of hours." Another told us, "I get put to bed at 6.30pm which is a bit early, but otherwise I have to wait until 8.00pm. A third person told us, "The lights go out at 9.00pm, but sometimes I want to watch things on TV later than that. The registered manager was aware as the issue had been raised in a previous residents survey. Since the survey they had introduced equality and diversity training for staff and followed up with discussion at staff meetings. At a recent residents meeting the registered manager had reminded residents that they had choices and people had confirmed that they could choose when to get up and when to go to bed. We are confident therefore that this is an area that the registered manager is monitoring and will continue to work on.

Rooms were comfortable and personalised. People told us they were happy with their rooms and that they had everything that they needed. Rooms were personalised with personal memorabilia and photographs. One person told us, "My room is beautiful." People did not always have a choice of a bath or a shower, as the assisted bath was not accessible for people who were assisted to move using a hoist. This meant that people who were unable to use the bath only had the choice of a shower or a bed bath. Generally people told us that they were happy to have showers and the registered manager told us she told prospective residents about the bathing facilities when they came to view the home but hoped to have the bath moved in the future to make it more accessible

People who attended the residents meeting in July said they were happy with the activities provided and that they had enjoyed the garden party in in June. The provider employed a dedicated activities coordinator who organised art and craft activities at the service on Mondays and Fridays and another who spent time one to one with people twice a week. One person said, "They try to keep us entertained, we did that button tree and those paper flowers over there. One to one visits were primarily for people who stayed in their rooms and included reminiscing with old photos about personal experiences, reading newspapers,

discussing steam trains or sharing tips on gardening. Entertainers and activities were booked to attend the service in addition to regular activities. These included musical performances and a golden years fitness class. Entertainment was booked at different times of day on different days of the week, so that everyone would have an opportunity to attend. On the day of inspection a trumpet player was booked to entertain people in the afternoon. The registered manager explained that one of the people living at the service used to play in a brass band. When the musician introduced himself the person recognised them and their musical connections. Their face lit up and they nodded and tapped their way through the entire session. People were invited to plan future activities and events in residents meetings and plan for Christmas were already underway.

There was a complaints process in place and complaints were recorded and responded to appropriately and within good time. The registered manager provided information and actively sought feedback from people and their relatives through meetings and surveys in order to involve people and improve the quality of the service.

Good

Is the service well-led?

Our findings

People felt that the service was well run and organised. Everyone we spoke to said they would recommend the service to others. One person said, "The atmosphere is very friendly and everyone is made welcome," and another told us, "It's very nice here, lovely atmosphere."

There was a registered manager in place. One health care professional said, "The manager is efficient and conscientious and in my opinion leads a safe team." People, staff and relatives had confidence in the registered manager and found them approachable. One person told us, "You can speak to the manager; she's here most of the time."

The registered manager was a registered nurse supported by a team of nurses. They worked direct shifts most days which enabled them to understand people's needs on a day to day basis. People knew the registered manager well, one person said, "She's a nice one and you can speak to her."

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications, in a timely manner, about any events or incidents they were required by law to tell us about. Staff and social and health care professionals told us that the registered manager acted in accordance with the requirements following the implementation of the Care Act 2014. For example, the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

The registered manager had implemented a quality assurance programme which included an infection control audit in March 2016 and a care plan audit in April 2016. Audits results had been analysed and fed back to staff along with their associated action plans. Results from a residents survey had also been analysed with any improvements monitored through talking to people at regular residents meetings.

Communal areas of the home were in the process of redecoration and residents meeting minutes documented that people had been consulted and were fully informed and involved in the project. People had been shown choices of wallpaper and flooring and asked which they preferred and the registered manager had gone through proposed schedule of works with residents so they knew what was happening and when.

Staff told us they felt supported and appreciated by the registered manager. One member of staff told us, "She is fair." Another member of staff said that the registered manager was, "Very organised." There were regular staff meetings and staff were invited to add items to the agenda. The registered manager said that sometimes it was easier for staff to raise an agenda item anonymously, so had implemented a suggestion box for staff to enable them to do this. The registered manager shared feedback and complaints at staff meetings and agreed actions with staff to improve the service. Other agenda items included fire safety, infection control and improvements to the dining experience for people such as tablecloths for the dining room tables.

The registered manager had built strong relationships with the local pharmacy and GP surgery. A health care professional who visited the service regularly commented on how the service worked closely with them to maintain people's health and wellbeing and avoid hospital admissions.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that medicines were managed safely and administered appropriately to make sure people are safe.