

Aegis Residential Care Homes Limited

The Laurels Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The inspection took place on 9 July 2018 and was unannounced. The last inspection took place on 18 June 2015. This was a focused inspection to follow up on a breach of regulation identified in December 2015 following a comprehensive inspection. The breach was in respect of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At the focused inspection we found this breach was met and the service was rated as Good.

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

The Laurels Care Home is a care home close to Congleton town centre. Originally a private house it has been renovated and extended to provide care to older people. It is a two-storey building and people live on both floors. Access between floors is via two passenger lifts or the stairs.

At the time of the inspection 33 people were living at The Laurels Care Home.

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

During this inspection we found the provider was in breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The breach related to staffing. Our observations showed that at different times of the day there were not enough staff on duty to ensure people received the support they needed to ensure their safety and well-being. Considering our findings, we have also made a recommendation regarding more robust monitoring at management level of the staffing arrangements in the home to ensure consistent staffing numbers are maintained.

Our observations showed when staff were supporting people they were attentive and tried to make people as comfortable as they could. Their time was limited as the home was busy however when assisting people they took time to understand people's different ways of communicating and to respond appropriately to their requests. Relatives were complementary regarding the attitude of staff who were described as caring and patient in their approach. People told us they liked the staff team and they were polite and respectful.

Staff had a good understanding of people's individual care needs and appropriate referrals to external healthcare professionals took place. Guidance and advice that was provided was being followed; this meant that people's overall health and well-being was being safely and effectively supported. Feedback from health and social care professionals who had input into the service was positive.

Systems were in place and followed to recruit staff and check they were suitable to work with vulnerable people.

We found the environment to be clean and free from any odour. Staff had access to protective clothing such as, gloves and aprons to support the control of infection.

The premises and equipment were subject to safety checks to ensure they were safe and well maintained. The premises was kept in good decorative order and there were some adaptations to promote a dementia friendly environment. The registered manager was aware that further work was needed in this area to fully support people with dementia. For example, more signage throughout the home to aid people's orientation.

People's medication was safely managed and they received it on time and as prescribed. Staff were trained and deemed competent to administer medicines.

Staff had a good understanding of people's individual care needs and appropriate referrals to external healthcare professionals took place. Guidance and advice that was provided was being followed; this meant that people's overall health and well-being was being safely and effectively supported.

Assessments of people's care needs had been carried out and people had a plan of care which provided in the main guidance for staff on how to meet their needs safely and effectively. We did however find that there were instances where staff had not inputted all the required information regarding people's support. We appreciate this was work in progress and the registered manager provided us with assurances this would be actioned.

Relatives were involved in the planning of their care to support their family member and they were kept up to date with matters relating to their health and welfare.□

Staff received training and support to help them support people in accordance with their individual need. Staff confirmed they received a good standard of training to support their learning and development.

Risks to people's safety and wellbeing were recorded to enable staff to support people safely whilst promoting their independence. Accidents and incidents were recorded and an analysis undertaken to look for trends or patterns to minimise the risk of re-occurrence.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made to protect them. This included applying to the local authority for a Deprivation of Liberty Safeguard (DoLS) for people.

Systems were in place for safeguarding people from the risk of abuse and reporting any concerns that arose. Staff had received training and knew what action to take if they felt people were at risk of abuse.

A system was also in place for raising and addressing concerns or complaints and people living at the home and their relatives told us they would feel confident to raise a concern. Complaints received had been logged and investigated but outcomes were not recorded. We brought this to the registered manager's attention to action.

People were supported to eat and drink enough to maintain a balanced diet and meet their dietary requirements. People were offered a good choice of meals and alternatives were offered if the menu choices

were not to their liking.

The provision of social activities was somewhat limited as the activities organiser was assigned one and a half hours a day to organise and facilitate social events. People were encouraged to participate and appeared to enjoyed the activities arranged.

There were systems in place to consult with people who used the service, to assess and monitor the quality of their experiences. This included completion of feedback surveys and meetings.

Systems were in place for checking the quality of the service to maintain standards and drive forward improvements; this included audits at service and senior management level.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. The ratings from the previous inspection were on display in accordance with requirements.

You can see what action we took at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe

Staffing numbers were not always maintained to ensure there were sufficient number of staff available at all times to support people safely and effectively.

There were systems in place to assess and monitor risks to people's safety and risks associated with the environment and equipment. The environment was monitored to ensure it was well maintained.

There were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Medicines were administered safely by staff who were trained and deemed competent.

Is the service effective?

Good ●

The service was effective

Staff supported people with their health needs and sought advice from external professionals to help keep people well.

Staff were supported through induction, appraisal and the service's training programme.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed.

People's dietary requirements were assessed and monitored. People were given a choice of meals which took into account their dietary needs.

Is the service caring?

Good ●

The service was caring

Staff were caring in their approach and when staffing numbers were satisfactory we saw staff providing support appropriately to people and in accordance with individual need.

People told us they liked the staff team and they were polite and respectful.

People and visitors were provided with plenty of information about the home and the services it offered.

Is the service responsive?

Good ●

The service was responsive

People had a plan of care which referred to their health needs and preferences and choices. Care documents were reviewed and updated to reflect change in care or treatment.

A process for managing complaints was in place and people and relatives knew how to complain. Complaints received had been responded to.

An activities organiser planned social arrangements which were varied and supportive of people living with dementia. There time was however limited due to the number of hours allocated each day to facilitate this.

There was a system in place to obtain feedback from people so that the service could be further developed with respect to their needs and wishes.

Is the service well-led?

Requires Improvement ●

The service was not always well led

Systems and processes were in place to monitor the service however we recommend the provider review and monitor more closely the staffing arrangements to ensure there are sufficient number of staff available at all times to support people safely and effectively.

The registered manager needs to work with staff regarding the development of the computerised care records to ensure they are complete and accurate.

There was a defined management structure with clear lines of accountability. The registered manager and staff team fully supported the values of the service and to make changes to benefit people living in the home.

The CQC had been notified of any reportable incidents and the service's CQC rating was displayed.

The Laurels Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection of The Laurels Care Home took place on 9 July 2018 and was unannounced.

The inspection team comprised of two adult social inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider was asked to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used this information to plan how the inspection should be conducted.

Some of the people living at The Laurels had difficulty expressing themselves verbally. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, 10 staff, including ancillary staff and the administrator. We spoke with 14 people living at the home and three visitors/relatives. We spent time looking at records, including three care records, three staff files, medication administration records (MARs), staff training matrix, complaints and other records relating to the management of the service. Prior to the inspection we contacted a commissioner of services who was involved with the service and during the inspection spoke with a visiting health care professional.

Is the service safe?

Our findings

We looked at the service's staffing arrangements and found that there were not always sufficient staff available to ensure people's safety and well-being. There was a risk people's needs were not being met.

We carried out observations of care during the morning from 9.40am to 10.20am using SOFI and further general observations until 10.55. Our observations in the middle lounge were positive with people getting support when they needed it. We were concerned that there was insufficient staff to support people in the 'garden room' (lounge/dining area) which compromised their care and potential safety. From 10am until 10.55am there were six people sat in the garden room with staff attending on two occasions. The first was to bring through a person in a wheelchair. The carer told the person they would 'get the hoist' to transfer the person to a chair] and then left. This was at 10.15am. We observed the person was still sat in their wheel chair at 10.55am when the staff returned to support people with drinks. The staff advised us they would be able to transfer the person "As soon as we can" stating it was very busy in the morning as people were getting up to start the day. During the same period, we observed a person shouting staff as they needed support to get to the toilet. With no staff present we left the area to find a staff to attend. We could only find one carer, who was attending to a visiting professional, as other staff were busy elsewhere in the home. When we returned to the 'garden room', the person shouting for assistance had been supported to the toilet by another person living in the home.

During the afternoon we saw there was limited interaction between staff and people sitting in the 'garden room'. Staff entered the 'garden room' at 2:02pm, 2:06pm and at 2:12pm with no interaction. At 2.15pm a domestic staff member spoke to one person. Between 2:17pm and 2:26pm a member of staff offered to play dominoes with a person in the 'garden room' and gave two people a drink and then left. At 2:45pm the same member of staff returned and apologised that they 'were busy in the other room so couldn't play dominoes'.

We asked people to tell us if they felt safe living in the home in respect of the staffing levels. We spoke with people in the 'garden room' who said, "You don't always see a lot of staff down here", "Staff don't come down here much. The lady before was shouting for quite a bit", "They are short staffed, definitely. You don't see staff for long periods. At night there is sometimes only two staff on for the whole home." Other feedback from people during the day included, "I feel isolated the staff don't have time to stop and talk", "Yes there are staff around but they are busy" and "There is not enough staff at night only two people for all the jobs they have to do and the hourly checks on us." A relative reported, "It is not as safe as it used to be. There are not as many staff as there used to be or they don't seem to have as much time for people."

At the time of the inspection the registered manager was on duty with a senior carer and three care staff. Another carer had come in to work on the new electronic care plans; they were not rostered to support people that day. Ancillary staff included, a cook, kitchen assistant, two domestic staff, a maintenance person and administrator.

The service used a dependency tool to assess people's dependencies covering different aspects of daily

living and this was used to plan the staffing levels. The registered manager informed us that staffing levels were adjusted in accordance with people's needs and that the staffing levels for nights were for three carers to be in attendance. We reviewed a staff duty rota for the home from 25 June 2018 to 8 July 2018 and saw there were numerous occasions when there were only two carers on night duty. This shortfall had not been rectified. For the night of the inspection we saw there were only two carers for nights and the same staff number for a number of nights over the next two weeks. In respect of days the registered manager told us they needed to increase the staffing levels to one senior carer and four carers as people's dependencies had increased. This included physical dependencies and support for people with dementia due to increased episodes of agitation and 'general' supervision needed. The registered manager told us they needed this increase in staffing to ensure people's safety and well-being with 10-13 people assessed as 'high' risk. The staffing rotas we looked at showed this increase was not being consistently maintained.

We fed back our findings from our observations, including the SOFI, to the registered manager. They informed us there was a core of staff who had worked at the home for 10 years or more, however, some carers had recently left and they were now recruiting for days and nights. They registered manager appreciated that the shortfalls in the forthcoming rotas needed to be addressed promptly. Staff told us the home was at its busiest in the mornings and this was when they needed more staff. A staff member gave us an example of when there were not enough staff to support a person with their meal.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we were advised by the registered manager that staffing levels had been revised and made safe.

We looked at three people's plan of care and this included management of risks associated with people's health and well-being. Risk assessments had been completed in areas such as, falls risk, diet, weight and nutrition, medication, skin integrity, bed rails and personal safety. These were monitored, reviewed and linked with people's plan of care to support them safely. One example was a person who, on occasions, had displayed a behaviour that put themselves and others at risk. We found the supporting care plan identified key triggers to this behaviour and gave some strategies for staff to support the person safely.

One of the people we reviewed had care notes and assessments on the (new) computerised care planning system. We found some of these assessments did not have enough depth and some were confusing. For example, one person was assessed as having 'mild pain' but there was no record of what this pain was. Another assessment for falls risk had been completed accurately however, the risk rating was inaccurately showing as 'high' risk. We fed these discrepancies back to the registered manager, so that the new system could be developed accordingly. The registered manager confirmed the actions they would take.

The service had a series of internal and external checks in place for the safety of the premises and equipment. This included checks of equipment, water temperatures, fire system, gas and electric supply. These checks showed that the building and equipment were safe to use. Information on how to support people in an emergency was available in the home. This included a fire evacuation plan and individual personal emergency evacuation plans (PEEPS) for people. The PEEPS file was 'regularly' audited to ensure the information was accurate; a list of people's medicines was also included for staff to refer to in an emergency. Recommendations from a review of the fire risk assessment of the premises were being actioned to ensure compliance.

Incident and accidents were logged and monitored by the registered manager and forwarded to regional

manager for further scrutiny. Reports identified emerging patterns and opportunities to reduce future occurrences. We saw where actions had been taken with the use of equipment such as sensor mats to reduce the risk of falls. For a person who had been identified at further risk the registered manager told us about more safety equipment that was being installed to reduce the risk of incidents to keep them safe.

Staff were trained in safeguarding procedures and understood their responsibilities to report any concerns of this nature. Records confirmed that safeguarding concerns had been identified and reported to the relevant authorities appropriately. Staff had access to a whistle blowing policy. This advised staff on the actions to take and the support they would receive if they raised a concern which affected people's safety and well-being. A staff member said, "I know who to go to and would report anything if I had a concern, and I can go to head office." Contact details for the local authority were available for staff to refer to for reporting purposes.

We found the management of medicines was safe and the systems in place helped ensure people were being monitored effectively. We made some observations of staff administering medicines in a safe and respectful way. Staff were trained and had been deemed competent to administer medicines.

All medicines had been checked upon receipt from the pharmacy and we were informed this was supported by the supplying pharmacist who attended the home on delivery and supported staff through this process. Medication Administration Records (MAR's) were complete and clear to follow. We found that people did get their medicines at the right times.

There were clear records on MARs when people had been prescribed topical creams and care staff had recorded each application. These were up to date records and showed people's creams were being used frequently, as prescribed.

Some people were prescribed one or more medicines to be taken only 'when required' (PRN). Extra information on how care staff should give these medicines (in the form of a protocol) was kept with the person's MAR, although new protocols introduced were being kept in a separate folder. This made these supporting care plans more difficult to access and the care staff responsible for medication management said they would discuss this with the registered manager so that PRN care plans could be placed with the MAR's.

Some people required a prescribed thickening agent adding to their drinks to enable them to swallow safely. We saw thickening agents were recorded and these records included details around the stage of thickener to be added to drinks to ensure the right consistency. Care staff updated some MARs with this information while we were on the inspection. When staff gave a drink with the thickener they made a record of this. Talking with staff confirmed their knowledge regarding their use.

Medicines were stored safely and kept at the right temperature. Both the temperature of the clinic room and the fridge temperatures were recorded and safely monitored. If medicines are not kept at the temperature advised by the manufacturer they may become less effective or even harmful.

Medicines that are controlled drugs (medicines subject to stricter legal requirements as they can be misused) were stored and handled safely. The stock balances of the controlled drugs we checked were correct.

The home had an up-to-date medicine policy describing how staff should manage medicines in the home. We saw that regular audits (checks) were carried out to see if staff followed the policy. Any required actions

were acted on promptly to improve practice.

We checked how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at three staff files and asked the registered manager for copies of applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. Identification for one staff member was missing in their file. We brought this to the registered manager's attention to action.

We found the home to be clean and hygienic. This included communal areas, toilets, bathrooms and bedrooms. Staff had access to personnel protective clothing, such as aprons, gloves and hand gel. These were being used appropriately during the inspection. The registered manager informed us that following a recent infection control audit by an external agency they had been advised that a sink for hand washing was required in the laundry room. Staff were using a bathroom for this purpose until a suitable hand sink had been installed. The registered manager said this would be actioned as soon as possible. Hand hygiene audits were completed to compliment the service's control of infection.

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had made applications for people to be supported on Deprivation of Liberty (DoLS) authorisations. The applications were being monitored by the registered manager in liaison with the local authority.

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.

An assessment tool was used to assess people's capacity to make 'key' decisions such as, use of bed rails, care and treatment. Where appropriate, people had signed to indicate their consent and it was clear to see people had been involved in the day-to-day decisions in relation to the care being provided.

We saw evidence of 'best interest' meetings which had been held and any decision made in a person's best interest were recorded; consent had been sought in line with good practice and guidance. Examples of consultation around key decisions could be found with the 'Do Not Attempt Resuscitate' (DNAR) decisions made and kept in people's care records. One of these was also supported by an 'Advanced Decision' statement. Overall, there was evidence that relatives were consulted with regarding any 'best interest' decisions including the initial admission to the home.

We asked relatives and people living at the home if they were happy with the care they received. People told us they received good care. In the main relatives spoke favourably though they were concerned about staffing levels which may have an impact on the care.

One person's care records were being updated and carried over to the newly installed computerised programme. We found the mental capacity care plan did not have the detail of the others we reviewed. It did not contain details of best interest decision made nor information about the DoLS authorisation the person was on. This was fed back to the registered manager and they said this information would be transferred from the 'paper' record.

During the inspection we observed staff seeking people's consent before supporting them. For example, when assisting with mobilising or where people would like to sit or have their lunch.

People were supported to maintain their health and well-being with the support of a range of community

health professionals. This included local GPs, dietitians, community nurses and opticians. A relative said, "If they (family member) are unwell they bring the doctor out and then call and tell me." Appointments were recorded in the care files we looked at and staff were following treatment plans where applicable. We spoke with a visiting health care professional who was involved in the support of people living at The Laurels Care Home. We were told that people were monitored well by staff who liaised effectively to support people's health care needs. Each person's care file included evidence of input by a range of health care professionals. If people had specific medical needs we saw these were documented and followed through. For example, one person had an indwelling catheter (tube passed into the bladder to help pass urine). It was easy to see when the catheter had been changed and the staff role in the monitoring of this.

We reviewed two people who had care plans on the computerised system to support aspects of their health care. There was a lack of detail on these care plans, as opposed to the paper records; for example, whether any health care professionals were involved in reviews. A supporting medication care plan also had very limited information. The registered manager advised that the care plan detail would be added to and the computerised records would be further developed to encompass all the relevant details.

Staff received training and support to provide safe and effective care for people. Staff attended four formal supervisions a year and received an annual appraisal. The registered manager informed us six staff were due an appraisal and these were planned in for the next few months. Staff had attending training on subjects which included, dementia, safeguarding, moving and handling, equality and diversity, fire evacuation and infection control; more specific training such as, pressure ulcer prevention, distressing signs, reactions and behaviours, diabetes, sepsis and person-centred care (individualised care) was provided to support staff practices. The registered manager and regional manager had highlighted some gaps where staff needed to refresh their training as only 12 staff were on 100% for their training. The registered manager confirmed the actions being taken to support staff with their e-learning and attendance at face-to-face training later in the year. We saw dates to confirm this and the registered manager was aware of the need to monitor this closely. Staff told us they received good training and support from the management team.

New staff received an induction in accordance with the Care Certificate. The Care Certificate is the government's blue print for induction standards which included a practical and competency framework for employees to follow. Staff undertook formal qualifications in care such as Staff told us they received a good standard of training and support. New staff were mentored during their induction to ensure they were fully supported. Staff completed training in care, such as, an NVQ (National Vocational Qualification). Over 69% of staff had an NVQ/Diploma qualification/ Diploma qualification to support their learning.

People's nutritional needs were assessed and monitored by the staff. We saw people received well balanced meals to meet their nutritional requirements. Some people had fortified drinks and soft diets these were served in accordance with people's assessed dietary needs. Insulated bowls were available to keep meals warm which was helpful for people who needed more time to eat their meals.

The menu was displayed in the main lounge in pictures on a board. The menu board was confusing and was not accurate. This was because the lunch pictures were of cottage pie and lemon pudding but cherry crumble and ice cream were served. The breakfast lunch and tea pictures were also mixed together and therefore not easy for people to follow. The cook went round in the morning to advise people of the menu choices and to offer an alternative if they did not wish to have the menu of the day.

A member of the inspection team had lunch with people living in the home and this was found to be pleasant dining experience. A four-week menu was in place and people were provided with meal options. People told us that in general they enjoyed the meals served and that they could ask for something different

if they did not like the meal selection. People said, "Too much tinned stuff for tea", "Lunch was very good the puddings are super" and "I really enjoy all the meals."

Adaptions to the building and equipment was available to make it easier for people to get around and receive safe support. This included the provision of bath aids, call bells, sensor mats and moving and handling equipment. The home had a secure garden to the rear with plenty of seating and shaded areas with large patio umbrellas. People who were mobile were able to move freely between the lounges and the garden and told us they liked home as it was spacious.

We saw measures to help orientate people and keep them safe. This included pictorial signs to indicate where specific rooms were, such as, bathrooms and toilets. The registered manager informed us signs for the dining room and lounges were on order as they appreciated the signage in the home needed to be more evident. We discussed the need to develop this on the first floor of the building to help people get around more easily and to aid orientation for people living with dementia.

Is the service caring?

Our findings

People told us, "The staff could not be kinder, the place is spotlessly clean and they are never rude" and "They are all very kind to me." We found the home to have a welcoming and friendly atmosphere and care was given to decorating people's rooms in accordance with individual taste and with their own personal items. A person told us the staff made it a 'real' home for them.

We found when staff did have time to support people they demonstrated reassurance, kindness, respect and patience throughout our visit. The SOFI carried out in the middle lounge recorded very good support and interaction by staff present. There was a good rapport displayed with many of the people living at the home and it was evident that care staff obviously care about people as individuals. In light of the very hot weather staff were very caring and attentive with respect to ensuring people received plenty to drink and sat in shaded areas of the garden, so as not to have too much sun.

People's communication needs were considered throughout their care plans. This included details about any sensory loss and included guidance to staff about how to support each person's individual need.

During the inspection we observed people's dignity and privacy being respected by staff in many ways. Staff knocked on people's door before entering and waited to be asked in. People's preferred name was used when staff spoke with them. At lunch we saw tables were set prior to the meal being served; dining room tables were set with a tablecloth and condiments included salt and pepper and assorted sachets of sauce were in a container on each table. People who required them were offered clothes protectors and these were removed to ensure people's dignity after lunch. People were not offered the opportunity to wash their hands before or after the meal.

Relatives told us the staff were polite and respectful and were always made welcome when visiting. We saw visitors arriving at different times of the day; visitors were offered light refreshments and could meet their family member in their bedroom. The home did not have any specific areas, such as a quiet lounge, where people could meet their family in private.

The home had information to support people's understanding and this included a brochure regarding the service. We discussed the brochure with the registered manager as it needed to be updated to evidence staff changes. The registered manager said they would action this. The service's brochure was available in people's rooms and in the main entrance of the home for people to read.

In respect of care documents this information was made available to people and their relatives. People were provided with opportunities to discuss and agree their plan of care; this also applied to relatives/and or their representatives when applicable.

Confidential information was correctly stored and protected in line with current governing legislation. Protected information was stored in locked offices/locked cupboards and was not unnecessarily being shared with others.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access. Staff told us they would support people to access these services if required.

Is the service responsive?

Our findings

People had a plan of care based on their individual needs and this considered their past medical history, personal choice and preferences. These covered areas such as mobility, skin care, personal care, daily life style and mental health. Care plans and supporting documents were reviewed 'regularly' and updated.

In respect of preferences, we saw information recorded around people's preferred food, time of getting up and retiring at night. This information was also recorded on 'My day' forms kept in people's bedrooms. These provided good information for staff to refer to and support people's care. Staff told us about people's care and support and their preferences and choices regarding their routine and activities. Staff told us there was good communication systems in the home and they were informed of any change in peoples' care or treatment. Care records contained information about people's sexuality, ethnicity, gender and other protected characteristics to ensure people's rights and choices were upheld. This included people's religious, spiritual or cultural requirements.

We checked whether the provider was following the Accessible Information Standard (AIS). This standard is important as it looks at providing people who have, for example, a disability, with information they can access and understand to help them communicate effectively. Staff told us how they made information accessible to people and care plans contained information about how people communicated. For example, writing things down for people who were hard of hearing and to speak slowly and clearly. The service had a large word and pictorial communication board and a large pictorial pain assessment board to help assess and gauge people's pain. These aids helped to promote good communication to enable people to make their needs clearly understood.

The service had a complaints' procedure which had been reviewed in September 2017. People, including relatives, we spoke with were aware of how they could complain. We saw there were records of complaints made; six complaints received since January 2018. We reviewed three of these and found they had been investigated by the registered manager in line with the home's policy. There was however, only one record of any feedback to the complainant. The registered manager advised us feedback had been given when the complaints were concluded. We discussed the need to record any feedback to close the complaints' procedure. The registered manager said they would action this. During the inspection relatives informed us of some 'general' concerns around attention to personal care and we brought this to the registered manager's attention.

The service had an activities co-ordinator who was also part of the domestic team. The staff member was allocated one and a half hours each day to facilitate and organise activities. People told us they liked to take part in different social activities and would welcome more trips out from the home. Relatives reported the same. We discussed with the registered manager increasing the hours allocated to organise social events. The registered manager was aware this needed to be considered to provide a more stimulating and meaningful programme.

On the day of the inspection, a small group of people went out for a walk along the canal and fed the ducks.

The following day staff were arranging to take people for lunch at a local church. This was a social event arranged by a church to encourage community integration. Some people were watching television with different programmes on in each lounge, some people had visitors and were enjoying sitting out on the patio, others reading and taking part in dominoes. There was a relaxed atmosphere.

Activities were advertised for people to read. This included, quizzes, bingo, jigsaws, film shows, zoo lab, visits by nursery school children, birthday celebrations, gardening and involvement with current events. For example, Wimbledon was being celebrated with strawberries and 'Pimms'. One person enjoyed gardening and was involved with choosing plants, flowers and tidying the garden. The service had a hairdressing salon and two hairdressers visited the home each week. People could attend a church service twice a month at the home. We saw staff recorded peoples' preferred hobbies and interests and an activities log was kept. This however was not kept up to date to evidence people's participation and enjoyment.

The registered manager was keen to seek feedback about the home to help assure the quality of the service. We saw people and their relatives had been invited to attend three monthly meetings and there was also a residents' committee, which relatives were invited to attend. People told us they could make suggestions which were taken on board by the staff and recorded feedback from the meetings was positive. As well as meetings, people and relatives were provided with satisfaction surveys. Where people and relatives had made suggestions, we saw the registered manager had acted on this. We saw sight of 'you said, we did' which showed suggestions made and actions taken by the service. This included changes to the menus with the introduction of different vegetables and the availability of wine, sherry and more soft drinks; introduction of key workers to support people; and more discussion around information recorded in people's support plans.

Staff received end of life care training and had links with local palliative care professionals to support their practice. At the time of the inspection no one living at the home was receiving end of life care though the registered manager showed us supporting documents, including risk assessment for changing needs, policies and 'best' guidance to support the provision for end of life care. People's plan of care recorded their decisions around end stages of life and final wishes. One person's 'advanced decisions' regarding their care was clearly communicated in their care file and known by the staff.

Is the service well-led?

Our findings

A long standing registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager spoke positively regarding their role and the support from the staff team and senior management team. The registered manager was receptive and open to our findings and it was evident they were committed to making positive on-going changes. Staff were aware of their responsibilities and who they were accountable to. They told us the home, in the main, was managed well.

We were however concerned regarding the lack of monitoring around the current staffing arrangements. Staffing shortfalls had not been covered to ensure there were enough staff. This was because our findings throughout the inspection showed a lack of staff support and interaction for people in the 'garden room' at different times during the day.

We recommend the provider review and monitor more closely the staffing arrangements in the home to ensure there are sufficient number of staff available at all times to support people safely and effectively.

The service had a quality framework to oversee standards and drive forward improvements. This included checks and audits of key areas to assure the safety and quality of key areas of the service. This framework was overseen by the registered manager who reported their findings to a regional manager. In turn this provided oversight for the senior management/compliance team and managing director. We saw audits were completed in areas such as, infection control, medicines, people's personal allowances, pressure ulcers, people's care including weights and moving and handling requirements, accident/incidents and environment/equipment checks. Any actions were identified and acted on to mitigate risk and improve the service. The regional manager completed a weekly report with actions for the registered manager to complete. We saw this included staff training which needed to be addressed and findings of a care plan audit. The registered manager told us about the actions they were taking to address these areas to ensure compliance. We saw sight of a 'snapshot survey' completed June 2018 by a compliance manager and company director. This provided evidence of how the service was operating in accordance with the Care Quality Commission's (CQC's) well led domain. The information we saw and completion of the service's PIR provided an over view of how the service was operating and how future plans would make a difference to people's lives.

The service had a business plan for 2018-2019 which outlined areas such as, the organisation's purpose and values and involvement of staff and people using the service. We discussed ongoing improvements with the registered manager. The registered manager told us that staffing levels would be improved to meet people's needs and we were assured by the measures taken following the inspection. The registered manager advised us of the new computerised care records. Some staff were competent in its use and explained the benefits. We saw this system had merit, however, we did identify some glitches in the assessments and care planning, as not all information had been transferred or was accurate. The registered manager told us how

this would be addressed. We appreciate this new system is 'work in progress' and how future developments will ensure the system is more effective.

The registered manager told us that work completed in the garden had been well received and there was a programme of on-going decoration for the home. The building is Grade 2 listed and therefore the service was working with the council regarding renovations that were needed due to general and wear and tear of the building. In particular this was in relation to replacing the windows at the front of the property. Further work was planned in promoting a dementia friendly environment.

The registered manager had introduced 'flash meetings' with senior staff to discuss emerging risks around people's safety so that these areas could be addressed quickly. They told us the newly installed call bell system was helping to monitor people's safety and reduce the risk of falls however we saw this had not worked as well in the 'garden room', as people had difficulty in calling for staff. This was due to lack of staff availability.

Considering the unusually hot temperatures, the registered manager had collated information and guidance for staff on how to care for vulnerable people in hot weather and where there was an increase in risk for people who were prescribed certain medicines. The registered manager had been very pro-active in ensuring people's health and well-being was monitored closely during this hot spell.

Changes to documents and training for staff was also being provided for staff to ensure they were familiar with the General Data Protection Regulation (GDPR) which came into force in April 2018. This is a law pertaining to data protection and privacy for individuals.

We saw evidence that the service worked effectively with other health and social care agencies to achieve better outcomes for people and improve quality and safety. External professional that we spoke with did not express any concerns about the quality and effectiveness of these relationships. A social care professional who conducted a quality review earlier this year informed us that feedback from people living in the home and relatives was positive with both reporting the home was 'well run', had a 'good family feel' and the staff delivered a good service.

Policies and procedures provided guidance to staff regarding expectations and performance in accordance with current legislation and 'best' practice. We reviewed some of the provider's policies which included, safeguarding, whistle blowing, infection control and recruitment. We saw policies were covered on staff induction and policy changes were communicated with staff.

It was clear that senior staff and the registered manager understood their responsibilities in relation to registration. For example, notifications had been submitted to us, the CQC, in a timely manner and the ratings from the last inspection were displayed as required, including the provider website.

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 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of staff available at all times to support people safely and effectively.