Tamby Seeneevassen

Amber House

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

This inspection took place on 7 February 2017 and was unannounced. At the last comprehensive inspection of the service in June 2015 we rated the home as Inadequate due to breaches in Regulation 12: Safe care and treatment, Regulation 15: Safety and suitability of the premises, Regulation 17: Good governance, Regulation 18: Staffing, Regulation 19: Fit and proper persons employed, Regulation 9: Person-centred care and Regulation 11: Need for consent. At the follow up inspection in December 2015 we found that improvements had been made. We rated the areas of safe and responsive as requires improvement, and the areas of effective, caring and well-led as good. There were no breaches of regulation and we judged that the overall rating was requires improvement. At the inspection in December 2015 we did not impose any requirements, but were concerned that staffing levels sometimes fell below those that were required and that people were not taking part in meaningful activities.

At this inspection we found that staffing levels were sufficient to meet the needs of people who lived at the home, and that efforts had been made to improve the type and availability of activities, although we considered there was room for further improvement.

The home is registered to provide accommodation and care for up to 41older people, including people who are living with dementia. On the day of the inspection there were 17 people living at the home. The home is situated in Bridlington, a seaside town in the East Riding of Yorkshire. The premises has three floors and a passenger lift operates between all levels. There are a small number of steps between split floor levels so only people able to manage the stairs can be accommodated in the areas that are accessed by steps.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

Care plans included information to guide staff on how to meet people's assessed care and support needs. However, we noted some anomalies or gaps in recording in care plans, positional change charts and medication records that could have resulted in people not receiving the care they required.

This was a breach of Regulation 17 (1)(2)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

We detected some malodours around the premises and we have made a recommendation about this in the report.

People were protected from the risk of harm or abuse because there were effective systems in place to

manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No-one living at the home had a DoLS authorisation in place but the registered manager had submitted applications that were being considered by the local authority.

There were recruitment and selection policies in place and these had been followed to ensure that only people considered suitable to work with people who may be vulnerable had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

Staff told us they received the training they needed to carry out their roles effectively and confirmed that they received induction training when they were new in post. Staff told us that they were well supported by the registered manager.

Senior staff had received appropriate training on the administration of medication. We checked medication systems and saw that medicines were stored and administered safely.

People who lived at the home and a relative told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home and staff, and that staff had a good understanding of people's individual care and support needs.

A variety of activities were provided and people were encouraged to take part, although people told us they would like to be more involved in the local community. People's family and friends were made welcome at the home.

People told us that they were happy with the food provided and we observed that there was ample choice. We saw that people's nutritional needs had been assessed and individual food and drink requirements were met.

The registered manager was aware of how to use signage, decoration and prompts to assist people in finding their way around the home, and some progress had been made towards making these available.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

Quality audits undertaken by the registered manager and senior managers were designed to identify that systems at the home were protecting people's safety and well-being.

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

Some aspects of the service were not safe.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Some malodours were detected around the premises.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles effectively.

People's nutritional needs were assessed and we saw that different meals were prepared to meet people's individual dietary requirements. People told us they liked the meals at the home.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and their advice was followed by staff.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as

possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs, their life history and the people who were important to them.

Activities were provided and visitors were made welcome at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. There were also opportunities for people who lived at the home to express their views about the service they received.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Record keeping at the home needed to improve. We identified gaps in recording on medication administration record charts and positional change charts, and saw there was some conflicting information in care plans.

The registered manager had submitted most notifications as required by legislation.

There was a registered manager in post, and people told us that they were well supported by the registered manager.

Audits were being carried out to monitor the effectiveness of the service. There were opportunities for people's relatives and staff to give feedback about the quality of the service provided.

Amber House

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 February 2017 and was unannounced. The inspection was carried out by one adult social care (ASC) inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider submitted a provider information return (PIR) as part of this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

On the day of the inspection we spoke with three people who lived at the home, one relative, three members of staff, the deputy manager and the registered manager. We looked around communal areas of the home and some bedrooms. We also spent time looking at records, including the care records for three people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home. These included records in respect of quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home told us they felt safe living at Amber House. One person said, "Yes, everything's safe; the building's safe and staff are around" and "Yes, plenty of locks on the doors and I have my own room key." This view was supported by a relative who we spoke with. They told us, "Staff are really good and [my relative] is checked." However, the relative added that they noticed positional change charts in their family member's room were not always completed consistently. This was confirmed when we checked the charts during the inspection. For example, one person's positional chart had an entry at 1.00 am on the day of the inspection, and no further entries. Two people's charts recorded that they had been assisted with a change of position at 6.30 am and when we checked their charts at 10.40 am and 11.20 am respectively the charts did not include another entry. The care plans for these three people recorded that they required two hourly positional changes. During the period in question we saw one of these people being moved by staff and the registered manager assured us that these people had been moved but staff had neglected to record this.

A member of staff told the registered manager that they kept notes throughout the day and entered the times on the positional change chart later in the day. Although this practice did not result in any harm to people who lived at the home, the registered manager informed staff that this practice was not acceptable. They assured us that, in future, charts would be completed at the time the assistance took place. We have addressed this in the Well-led section of this report.

Staff described how they kept people safe. They told us, "We keep the environment safe and clean, make sure there are no hazards and keep people safe when they are in bed and when they are up and around" and "We check the environment, we transfer people safely, we check equipment and we check that staff are available to help." Another member of staff told us that moving and handling training at the home was done each year and was "Very thorough."

Information to advise staff how people should be assisted to mobilise was included in care plans. On the day of the inspection we observed staff using equipment to move people safely. Staff took their time, chatted to people and reassured them during this process. We saw that people also had equipment in place to protect them from the risk of developing pressure sores.

Staff told us that they had completed training on safeguarding adults from abuse, and that they completed regular refresher training. This was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager or the deputy manager and that they would "Write everything down." The registered manager told us that she and the general manager were due to attend 'cascade' training provided by the local authority on safeguarding adults from abuse so they would be able to provide this training for staff.

Staff told us they would not hesitate to use the home's whistle blowing policy if they had cause to. Whistle blowing is when a member of staff or ex member of staff reports concerns about unsafe practices at their

workplace.

We checked the recruitment records for three members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with people who may be vulnerable. Documents such as photographs to identify the person had been retained. We saw that interview questions and responses were recorded and held for future reference.

On the day of the inspection we saw that there were sufficient numbers of staff on duty to meet people's needs. This included the registered manager, the deputy manager and three care workers. The rotas evidenced that these staffing levels were usually maintained, and that there were two 'waking' care workers on duty overnight. People told us that there were sufficient numbers of staff on duty. Staff told us that staffing levels were satisfactory and that, when a member of staff was absent from work, they were asked to work an additional shift or they contacted one of their 'sister' homes to request cover. They could also use agency staff. One member of staff said, "We are a good team. We work well together. I'm happy with the levels [of staff] when everyone is in."

In addition to care staff, there was a cook and a domestic assistant on duty each day. This meant that care staff were able to concentrate on supporting and caring for people who lived at the home. We noted that there was always a staff presence in communal areas of the home and that people did not have to wait for attention.

A relative told us there were enough staff on duty. They commented, "Whenever I visit, yes. If I ask for anything it is done." One person who lived at the home said there were enough staff on duty. However, another person told us, "There are shortages of staff at times. I usually have to wait ten to fifteen minutes for staff." We fed this back to the registered manager, who told us the call bell system had a facility to allow them to monitor response times. They had checked these records and there had only been two occasions when this person had waited longer than 15 minutes for attention. The registered manager told us they would now carry out this exercise every month.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for toiletries stored in people's bedrooms, falls, use of a wheelchair, use of the hoist, tissue viability, use of the call bell and showering / bathing. Risk assessments recorded the risk, any triggers, how staff could reduce the risk and how the risk could be eliminated. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date.

Staff told us that they never used physical restraint. We saw that care plans recorded possible behaviours that might challenge the service, and how staff should manage these behaviours to defuse such situations. One care plan recorded, 'Staff to remain calm and use diversional techniques. [Name] may respond better to another member of staff'. This was referred to as the 'walk away' policy.

There was a contingency plan in place that included advice for staff on how to deal with emergency situations such as a disruption to power, utilities failure, flood and severe weather conditions. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

There was an appropriate policy and procedure in place on the management of medicines. We observed that medicines were appropriately ordered, received, recorded, administered and returned when not used. Medicines were supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day.

Medicines were stored securely in a medicines trolley that was stored in a locked treatment room. Controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medicine and saw that the records and medicine held in the cabinet balanced.

There was a fridge available to hold medicines that needed to be stored at a low temperature. We saw that the temperature of the medicine fridge and the area where medicines were stored were checked to ensure that medicines were stored at the correct temperature. Medicines that needed to be returned to the pharmacy were stored securely and recorded in a returns book. There was an audit trail to ensure that medicines prescribed by the person's GP were the same as the medicines provided by the pharmacy.

We looked at MAR charts and found that they were clear, complete and accurate. Handwritten entries were signed by two people; this reduced the risk of errors occurring when transcribing information from the label on the medicine to the MAR chart. We saw there were protocols in place for the administration of 'as and when required' (PRN) medicines. Codes were used correctly to record the reason medicines were not administered. However, there were a small number of gaps in recording. We ascertained that these were gaps in recording rather than gaps in administration. There was a laminated sheet for each person who had a MAR chart in place and these recorded the person's photograph, any known allergies and their date of birth. This helped new staff to identify people who they assisted with the administration of medicine.

Staff told us that only the registered manager, the deputy manager and senior staff were responsible for the administration of medicines. The training records we saw recorded that seven members of staff (including the registered manager) had completed training on the administration of medicines. Medicines were audited each month and we saw that the audit for January 2017 recorded that minor recording errors had been noted and that these had been addressed with staff.

We checked the accident and incident records in place at the home. The registered manager completed a monthly analysis of falls and accidents; this included the number of incidents, the severity of the incident, any injuries sustained and any medical attention required. Body maps were used to record any injuries or wounds, which helped staff to monitor the person's progress. One person's records showed they had been assessed at the 'falls' clinic and a referral had been made for physiotherapy due to the high number of falls that had occurred. This showed that action had been taken following accident monitoring.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, fire extinguishers, portable electrical appliances, gas safety, the electrical installation, the passenger lift and hoists and slings. In addition to this, the home's water tanks had been checked to ensure the safety of the water supply, and the emergency call bell system had been replaced.

There was a fire risk assessment in place and the home had been visited by a Fire Officer. We saw evidence that the recommendations they had made had been actioned.

People who lived at the home told us the home was maintained in a clean and hygienic condition. One person told us, "The home is spotlessly clean." Records showed that daily and monthly room checks were

carried out by the registered manager to monitor safety and cleanliness. Any shortfalls were recorded on the checklist and there was a record of when remedial action had been taken. Infection control audits were carried each month. However, we found that there was a smell of urine in the entrance hall and outside some people's bedrooms at times. This was confirmed by a relative, who commented, "There is a smell of urine in the main room, but this can't be helped."

We recommend that the registered provider monitors cleanliness and hygiene practices and takes the appropriate action to ensure the home is free from malodours.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

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 MCA 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. We saw that some applications had been submitted to the local authority for consideration but none had yet been authorised.

The training record showed that staff had completed training on the MCA. Staff who we spoke with understood the principles of the MCA and confirmed they had completed training on this topic. Each area of a person's care plan included a MCA statement. This recorded whether the person understood the information, whether they could retain the information and if they were able to communicate their decision.

There were forms in care plans that recorded people's consent to having a photograph taken for their care records, and to the content of their care plans. People had signed these when they had the capacity to do so. We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. People told us that staff asked for consent before they assisted them . One person said, "I am independent but they ask."

We asked staff how they assisted people to make decisions. Their comments included, "We take clothes from the wardrobe and ask people to choose. We have picture menus", "Choices are about menus, the drinks trolley, bedtimes, a shower or a bath and a choice of clothes" and "We offer a choice of food and drinks, bedtimes, what to wear, when to shower. Everything is their choice."

Information about people who had a representative to act on their behalf was recorded in care plans. One person's records showed that the local authority was their corporate appointee and another person's records included correspondence from the Office of the Public Guardian stating that they had a deputy appointed to look after their property and financial affairs.

People who used the service and a relative told us that staff seemed to have the skills they required to carry out their roles. Staff told us they had completed a thorough induction programme and this was confirmed in the staff records we reviewed. Induction training included the topics of fire safety, emergency first aid, food hygiene, the control of substances hazardous to health (COSHH) and infection control.

The registered manager told us that the training that was considered to be essential by the home was fire safety, moving and handling, health and safety, infection control and safeguarding adults from abuse. They said that, moving forward, dementia awareness would be added to this list. We checked the home's training matrix and this showed that staff had completed this training. Other training provided for staff included first aid, MCA / DoLS, challenging behaviour and pressure area care. Seven members of the senior staff group had attended medication training.

Most staff had achieved or were working towards a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3. NVQ's have been replaced by the Regulated Qualification Framework (RQF). Although it has not been put into legislation and is therefore not mandatory, it is the benchmark that has been set for the induction of new healthcare assistants and social care support workers and is therefore what we should expect to see as good practice from providers. The registered manager told us that new staff were currently not expected to complete the Care Certificate. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. The registered manager explained that new staff were enrolled directly on to the RQF.

Staff told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. One member of staff said, "If I feel I need any training, I ask and training is given" and another told us, "I am starting NVQ 3. The manager has a list of my training requirements."

Staff told us that they had supervision meetings with the registered manager or a senior member of staff and they felt they were well supported. Comments included, "My last supervision meeting was a couple of months ago. I feel I have got the support of the management. The door is always open" and "I have just had a supervision meeting with a senior. I feel supported" and "The manager's door is always open. They have been an absolute angel to me. They are always at the end of the phone."

We saw that, if there had been concern about a particular area of staff practice, an additional supervision meeting was arranged to discuss this further. A senior member of staff told us that staff were closely monitored if any concerns had been expressed about their practice, and that they were 'mentored' and supervised in an effort to drive improvement.

People told us that they could see their GP whenever they needed to. One person told us, "If I wasn't very well they would contact my GP" and another person said, "I can get to the doctors on my scooter. I saw a district nurse after my fall about two weeks ago and she said it is all ok now." Staff told us they would inform the senior care worker on duty about their concerns, and the senior care worker would ring the GP surgery to request a visit.

People had patient passports in place. These are documents that people can take with them to hospital appointments and admissions when they are not able to communicate information about their care and support needs to hospital staff. They provide hospital staff with information about the person to enable them to meet their needs. Relatives told us they were kept informed about their family member's health and welfare, such as visits from their GP.

People told us that they liked the meals at the home. One person told us, "[The food is] alright. I get a good choice. I had cornflakes for breakfast, hot meal for lunch and sandwiches at tea time. I get enough to eat" and "There's a good cook. Good variety. My favourite is garlic mushrooms and she does them for me." Staff told us that people's dietary needs were recorded in their care plan, and that there was a list in the kitchen that recorded people's special diets as well as their likes and dislikes. The cook showed us this list. They told us that they prepared fortified diets, pureed diets and diets for people with diabetes, and that some people

required 'thickeners' in their drinks. The cook told us that when she was not at work, care staff were aware of people's needs and that they had access to the kitchen over a 24 hour period, so were always able to provide people with snacks.

There was also a blackboard close to the dining room that recorded the day's menu. The registered manager showed us some laminated picture menus that had just been developed and were due to be put into use. The cook told us that the two choices of main meal were explained to people each morning so that these meals could be prepared. If people did not want one of the choices on offer, staff would provide an alternative. We saw they had prepared one person an omelette on the day of the inspection.

We saw that people had a nutritional screening tool in place, and that their nutritional requirements were recorded on a catering information sheet. One person's sheet recorded, 'Needs fortified foods but not supplements. Normal diet but needs encouragement to eat'. Referrals had been made to dieticians or the speech and language therapy (SALT) team when concerns about nutritional intake had been identified. Staff also told us that people had food and fluid charts in place to monitor their intake and that they followed any advice given by dieticians.

We observed the serving of lunch in the dining room. Tables were set with tablecloths, glasses and serviettes, and people were offered a clothes protector. The meal looked hot and appetising and people were offered a choice of drinks and desserts following the main meal. Staff offered people appropriate support to eat their meal and they checked whether people wanted 'second helpings' and that they had finished their meal before plates were removed. Specialised equipment was provided when people had been assessed as requiring this support. One person was reluctant to eat and another was reluctant to sit at the table. We saw that staff offered appropriate encouragement and support.

Because there were vacancies at the home, there were currently no occupied bedrooms on the top floor of the home. The registered manager told us they had taken the opportunity, following consultation with people and / or their relatives, to move more dependent people to the ground floor so they could be closely supervised.

People told us they could find their way around the home easily. Staff told us that some of the doorways were "A bit small" but that otherwise the premises were suitable for the people who lived there. One member of staff added, "The signage has got better." We saw that there was signage to assist people to find toilets and shower rooms, and some bedrooms. Bedroom doors were painted in different colours and some had pictures or a room number displayed to help people identify their own bedroom. New plain flooring had been fitted in downstairs and some upstairs corridors and walls were painted a pale colour; research shows that people with cognitive difficulties find plain flooring and decoration less distracting and confusing. These prompts helped people who were living with dementia to orientate themselves within the home.

Communal bathing facilities at the home consisted of two shower rooms and one bathroom with a shower. The assisted bath seat had recently been removed and the registered manager told us they were awaiting a replacement.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Their comments included, "Staff are very pleasant" and "I think they are [caring]. I have nothing to complain about." A relative told us, "The staff are really good. All so nice with [my family member]. Far superior than the last home."

Staff told us they were confident everyone who worked at the home genuinely cared about the people who lived there. They told us, "Yes, we know them and get to learn things about them" and "Yes, staff treat them like their mothers or grandparents." We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to people who used the service and to help us understand their experience of living at Amber House. We saw positive interactions throughout the day between people who lived at the home and staff. We saw that people were comfortable in the presence of staff, and that staff were kind, attentive and patient.

Staff told us they promoted people's independence. Staff comments included, "We get them to do as much as they can", "We encourage them to do things themselves" and "We encourage people to wash and feed themselves." We saw this to be the case on the day of the inspection. We also saw that people were well groomed and dressed in their chosen style.

People told us that staff shared information with them appropriately. One person said, "They talk to me in a morning. I understand them; they will tell me what is going on." Another person told us, "They are too busy to talk to me, although they will have a natter to me in the smoke room." We saw that a newsletter had been introduced in February 2017 and we were told they would be issued every two months. This provided one way of keeping people informed of events at the home.

We observed that people were treated with dignity. We saw that staff knocked on doors and asked if they could enter the room. This was confirmed by a relative who we spoke with, who commented, "Staff always knock before they come in the room." One person who lived at the home told us, "Letters are handed to me unopened and they knock on doors." Staff told us that they respected people's privacy when they were assisting them with personal care. One staff member told us, "We use towels to cover people, make sure doors are shut and if they want to be alone we let them" and another said, "We close curtains and doors, cover people up when undressing and knock on doors."

People had a 'dignity' statement in their care plans. This stated: Dignity means being listened to, being respected, being visible'.

One person was supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's different needs. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. One person's care plan recorded that they were 'non practicing Church of England' but enjoyed joining in the church services and choirs.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We observed that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included communication, personal care, tissue viability, diet and nutrition, continence, pain, mental health, social needs and advanced wishes. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

We saw that care plans included information about people's life history, including their likes and dislikes. There was information to help staff identify people's needs. One person's care plan recorded, 'If [name] does not want to interact they will close their eyes and pretend to be asleep'. We asked staff how they got to know about people's individual needs and they told us they read care plans and spoke with relatives. One member of staff said, "We do our best to have a chat and find out their likes and dislikes and put this in their care plan" and another told us, "We try to make it one to one. I care as much as possible and try to find out what they like." This information helped staff to provide individualised care.

People told us they were not sure whether they had a care plan but a relative told us they had been involved in developing their family member's plan of care. We saw that, as staff became aware of additional information about a person, this was added to their plan of care. Care plans were reviewed each month and updated as required.

However, there were some anomalies in recording. For example, one person's care plan recorded that they could use the call bell and also that they could not use the call bell to summon assistance. Another person had two different dependency scores recorded in their care plan. This provided conflicting information for staff which could have impacted on the care people received. This has been addressed in the Well-led section of this report.

Staff told us they had handover meetings at the beginning of each shift. We checked the handover sheet for some recent shifts and saw they recorded the names of the staff on duty during the day and night. Appointments, professional visits, specific tasks for members of staff, activities that people had taken part in, people who had requested assistance with a bath or shower and a discussion about each person who lived at the home (such as any concerns or changes to their health) were all included. Staff said this helped them to keep up to date with people's current care needs.

A relative who we spoke with confirmed they felt there was good communication between themselves and staff at the home. They said, "Yes, whenever I ask I am told truthfully."

Staff told us that they supported people to keep in touch with family, friends and the local community. Comments from staff included, "We welcome visitors and we help people to use the phone" and "We

encourage and assist people to write to families. We enclose a photo. We make drinks for visitors." A relative who we spoke with told us that they could visit the home at any time and were made to feel welcome.

People who lived at the home told us they would like more activities, and to be more involved in the local community. One person said, "I would like [to take part in] anything. I'm not part of anything outside of the home" and another person told us, "I would love a trip out. I do go out on my scooter to a local coffee shop." A relative told us that there did not seem to be many activities on offer, but that staff included their family member in activities if they were interested.

The registered manager had recognised that more suitable activities needed to be provided for people. An activities 'champion' had been given responsibility for ensuring activities took place. 'Champions' are staff who take a special interest in a topic and share relevant information with the rest of the staff group. We saw that a small number of activities took place during the day such as nail care and singing. We spoke with the activities 'champion' and it was apparent they were enthusiastic about their role. They told us they planned to arrange special parties for people's birthdays and they had contacted the local library to enquire about 'talking books'. They also mentioned that they were going to ask and encourage people who lived at the home to knit hats for premature babies born at the local hospital. Other staff told, "I have been bringing things in for the residents and I encourage them to take part in any activities" and "We play skittles and ballgames. We had a movies and popcorn day yesterday and when the weather is fine, we take people out." We observed that staff made efforts to engage people in conversation and encouraged people to join in activities.

The activities folder recorded all activities that people took part in. We saw that the records for 2016 showed only minimal activities had taken place. The records for 2017 showed that activities were taking place on a more regular basis.

The complaints log showed that one formal complaint had been received during 2016. This had been investigated by the registered manager and an apology had been sent to the complainant. This meant that the complaint had been dealt with in line with the home's policy and procedure.

We noted that a 'suggestions and comments' box had been place in the reception area of the home. This showed that people were encouraged to express their views.

People who lived at the home told us that they were able to express their concerns, and they told us who they would speak to. One person said, "I would speak to [name of registered manager]" and another said, "I would tell anybody, but I have never had to." Staff told us they would pass on any complaints to the registered manager or deputy manager. Comments from staff included, "I would inform a senior or management. I would write it down in the daily report" and "I would tell a senior, the deputy or the manager. Although it depends on the complaint. I would deal with a minor one myself, such as socks missing in the laundry." A relative told us that they had complained to the home and that they received a response from staff.

People who lived at the home told us that they were not aware of 'resident' meetings or a newsletter, and that they had never completed a satisfaction survey. However, we saw copies of a catering survey that had been carried out in January 2016 and then repeated in January 2017. The 2017 survey had not been analysed but the 2016 survey showed that most people were satisfied with the meals on offer, and that they had been invited to make suggestions for changes on future menus. We saw some of these changes had been incorporated into the new menus.

We saw that meetings were held for people who lived at the home and their relatives. There was a notice in the entrance hall that recorded the dates of meetings throughout the year; these were planned to be held each month, and the most recent meeting had been on 31 January 2017.

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found the registered manager had informed CQC of most significant events in a timely way by submitting the required 'notifications'. We reminded the registered manager that notifications in respect of safeguarding adults from abuse needed to be submitted to CQC even when the threshold tool distributed by the local authority indicated that no alert needed to be submitted. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

We looked at a variety of records and documents during our inspection, including people's care plans and other documents relating to their care and support. We found that there were some omissions in recording, such as a small number of gaps in MAR charts, gaps in positional change charts and anomalies in care plans that could have resulted in people not receiving the care that they required.

These shortfalls in recording are a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

We observed that the registered manager interacted with people who lived at the home throughout the day and that these interactions were positive and friendly. It was clear the registered manager knew the people who lived at the home, and people told us they knew who the manager was. One person told us, "I know her but not her name. I can talk with her" and another said, "It is [name of registered manager]. She is easy to talk to and approachable."

We asked staff what they felt about the management and leadership at the home. They all responded positively. One person said, "[Name of registered manager] is brilliant. You can always go to the manager if you have a problem." Another person told us, "I can see the difference; there have been a lot of improvements." They added that staff also received good support from the organisation's general manager who was "Always at the end of the phone."

The registered manager carried out various quality audits to monitor that the service was being operated safely and to meet people's assessed needs. These included audits of accidents and incidents, medication, pressure damage, the dining experience, care plan reviews, infection control, health and safety and safeguarding adults from abuse. The care plan audit recorded that one person did not have a patient passport in place. We checked their records and noted this document had been completed. This showed that shortfalls identified in audits were acted on.

Staff described the culture of the home as "A good atmosphere; we talk over any problems" and "Open; we can talk to staff and the manager about anything." A relative described the home as, "Much friendlier and it's

easier to talk with the staff than at the last home. They do seem to care."

Staff meetings were held and staff told us they could ask questions and make suggestions at these meetings. One member of staff added that they were always told what had been discussed at staff meetings if they were unable to attend. We saw the minutes of meetings held in December 2016, and these showed that the topics of activities and documentation were discussed. Two meetings had been held in January 2017, one for care staff and one for senior staff. The topics discussed at both meetings included medication, the key worker role and documentation. It had been identified that monitoring charts were not being completed accurately and the importance of consistent recording was stressed.

There was an activities 'champion' at the home and the registered manager told us that they planned to have other champions, including those for infection control and nutrition. It would be the role of these 'champions' to take a special interest in their topic and share good practice and relevant information with the rest of the staff group.

Staff told us that they learnt from incidents that occurred at the home. They gave an example of one person's room being cluttered leading to them having a fall, and how they were now more aware of keeping the environment hazard free.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. Reg. 17 (1)(2)(c)