HC-One Limited

Pendleton Court Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 4 June 2015.

Pendleton Court care home is located in Salford, Greater Manchester and is owned by HC-One Ltd. The home is registered with the Care Quality Commission (CQC) to provide care for up to 58 people. There are three separate units at the home, each providing care to people with residential, nursing and dementia care needs. Our last comprehensive inspection of the home was on 23 April 2014 where the home was judged to be non-compliant in relation to safe management of medication. We also conduced a follow up inspection on 16 October 2014 to see if improvements had been made in relation to the safe handling of medicines. However, we found the provider was still non-compliant in this area. This inspection focussed on what improvements had been made since our last visit.

During this inspection we found a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment with regards to medication.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We checked to see if medication was handled safely. During this inspection we looked at records about medicines for 14 people. We saw there was some good practice around medicines handling, however we still found concerns about medicines safety for all 14 people. This meant that overall people were still at risk because medicines were not being handled safely.

The people we spoke with and their relatives told us that they felt safe whilst living at the home. One person said to us; "I do feel very safe. If I ever feel unwell they are there straight away and do something about it".

During the inspection we spoke with staff about their understanding of safeguarding vulnerable adults. Each member of staff was able to describe the process they would follow if they suspected abuse was taking place. One member of staff said; "Initially I would report my concerns to the manager or team leader to seek further advice on what to do. I would also check that it has been followed up and that something was being done about it".

We looked to see whether there were enough staff in order to meet people's care requirements. The nursing unit was staffed by four care assistants and a lead nurse for the unit. This was to provide care for 23 people. Both the residential and dementia unit were staffed by two care assistants and a team leader who seemed to work between both units. There were 22 people living on the residential unit and nine people living on the dementia unit. An additional member of staff was working on the residential unit during the inspection, who had worked at the home previously in a student placement role, but had not yet undertaken any formal training. Through speaking with staff they felt staffing levels were not adequate, particularly on the residential and dementia units. One member of staff said; "Staffing levels are very bad on here. With the team leader working between two floors, there are often only two of us down here. We are constantly playing catch up. Sometimes it can be absolutely chaotic".

We found staffing levels at the home were defined by the number of people living on each unit and not by the levels of dependency. This meant that at times there were insufficient staffing levels to offer the care required. However these were not being brought together to inform staffing levels. This meant the service could not demonstrate that staffing levels reflected the needs of people who use the service.

Through our observations during the day, we felt there were insufficient staffing levels at the home, to meet people's needs in a timely manner. These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

We looked at staff personnel files to ensure that staff had been recruited safely, with appropriate checks undertaken. Each file we looked at contained application forms, CRB/DBS checks and evidence that at least two references had been sought from previous employers. CRB and DBS checks are used to establish if staff have any criminal convictions.

During the inspection we checked to see if the environment was suitable for people living with dementia and what adaptations had been made. We found these to be limited on the residential unit, where we were told approximately 20 people lived with dementia. For example, there was no signage around the unit, which would help people correctly locate where the dining room or lounge area was. Additionally, things such as hand rails and toilet seats were not bright in colour which again, would make them easier for people to locate. There were also no specific memory boxes or items people could touch or relate to as they walked around the unit. The corridors on the unit were long and at times we saw people appeared confused about finding different rooms on the unit and asked where they were.

We looked at what training staff had undertaken to support them in their role. Staff had a variety of training at their disposal including moving and handling, safeguarding, MCA/DoLS, infection control and dementia. The majority of training was done through eLearning and we saw that approximately five members of staff were not up to date in all of these topics and that the completion dates for these courses had now expired. We raised this with both the home manager and area manager who

Summary of findings

were aware of this and that a deadline of the 30th June had been given for completion before moving to disciplinary procedure. We found that training for the remaining staff was up to date.

We observed the lunch time meal served at the home, on each of the three units. We saw staff displayed a good understanding of people's nutritional needs and offered choice where necessary. Some people required a 'modified' diet and we saw this was provided for them in order for them to consume their food safely. Some people chose to eat in their bedroom and we saw staff took people their meals on request.

We saw that staff received regular supervision as part of their ongoing development. This provided an opportunity to discuss their workload, any concerns and any training opportunities they may have. We saw appropriate records were maintained to show these had taken place.

The people we spoke with and their relatives told us they were happy with the care provided by the home. One person living at the home said to us; "In general, I'm quite happy with the care here".

We saw that people were treated with dignity, respect and were allowed privacy at times they needed it. We saw people looked clean, were well presented and were able to choose how they spent their day which was respected by staff. We saw that when entering people's bedrooms to provide personal care, staff closed the doors behind them to respect people's privacy.

We found that complaints were responded to appropriately, with a policy and procedure in place for people to follow when they needed it. Additionally, we saw that a response had been provided to the complainant, letting them know of any action that had been taken. A full description of the homes complaints procedure could be found in the homes 'service user guide', although was not displayed anywhere in the home.

There were various systems in place to monitor the quality of service provided to people living at the home. These included regular audits and by gaining feedback from the service through surveys which were sent to relatives and people who lived at the home. This was usually done each year.

We saw that there were regular audits and checks made by senior management of the company, which covered different aspects of the service. The most recent medication audit was done on 1 June 2015 stating that there was safe medicines management in the home. The audit failed to pick up the concerns we found during our inspection visit. This meant that the homes auditing processes were not always robust enough to identify concerns.

The staff we spoke with were positive about the leadership of the home. One member of staff said; "I think the manager is very good. She is very approachable and fair. I feel I can also speak with her as a friend".

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Not all aspects of the service were safe. We found that medication was not handled safely which placed people at risk.

The feedback we received from staff on the residential and dementia unit was that there were not enough staff to care for both nine and 24 people on each unit. We also felt this through our observations.

The staff we spoke with displayed a good knowledge of safeguarding adults and could describe the process they would follow if they had concerns.

Requires improvement

Is the service effective?

Not all aspects of the service were effective. The residential unit in particular, had no adaptations with regards to making the environment suitable for people living with dementia.

Staff had access to a range of training to support them in their roles. This was done through eLearning which staff could do in their own time. We found certain staff required updates in some areas. This was, however being monitored by managers at the home.

Staff supervision was consistent, with records maintained to show that a regular pattern of supervisions had been maintained previously.

Requires improvement

Is the service caring?

The service was caring. The people we spoke with and their relatives told us they were happy with the care provided by staff at the home.

We saw people were treated with dignity and respect and were allowed privacy at the times they needed it.

People were offered choice by staff and we saw they were able to choose how and where they spent their day.

Good

Is the service responsive?

The service was responsive. Each person living at the home had an initial care needs assessment in place, which then allowed staff to create a care plan based on their personal needs.

We saw complaints were handled and responded to appropriately with an appropriate response given to each complainant.

There was an activity schedule in place. On the day of the inspection there were various music activities taking place for people living at the home.

Good

Summary of findings

Is the service well-led?

Not all aspects of the service were well-led. There was a manager in post who was registered with the Care Quality Commission.

Although there were systems in place to monitor the quality of service provided at the home, we found that audits of medication were not robust and did not identify the concerns we found during our inspection.

Staff who worked at the home felt the home was well-led and that the manager was approachable.

Requires improvement 

Pendleton Court 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We carried out this unannounced inspection on 4 June 2015. The inspection team consisted of an adult social care inspector, a nursing specialist advisor, a dementia care specialist advisor and a pharmacist inspector. The pharmacist inspector was following up on previous non-compliance in relation to management of medication.

At the time of the inspection there were 54 people living at the home. During the day we spoke with the registered manager, assistant operations director, six people who lived at the home, six relatives, nine members of staff and two visiting professionals. We looked around the building and viewed records relating to the running of the home and the care of people who lived there. This included care plans, staff personnel files and policies and procedures.

We spoke with people in communal areas and their personal rooms. Throughout the day we observed how staff cared for and supported people living at the home. We also observed lunch being served in both dining rooms of the home.

Before the inspection we liaised with external providers including the safeguarding and infection control team at Salford local authority. We also looked at notifications sent by the provider as well as any relevant safeguarding/ whistleblowing incidents which had occurred.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. Comments included; "I do feel very safe. If I ever feel unwell they are there straight away and do something about it" and "I feel safe. I'm cared for in bed all day but the staff always check on me which is one of the main reasons" and "I'm quite safe here". A visiting relative added; "My relative is very safe and well cared for whilst living here".

During the inspection we spoke with staff and asked them about their understanding of safeguarding vulnerable adults. Each member of staff could clearly describe the process they would follow if they had concerns about people's safety. One member of staff said; "Initially I would report my concerns to the manager or team leader to seek further advice on what to do. I would also check that it has been followed up and that something was being done about it". Another member of staff said to us; "I would not hesitate to report my concerns to senior management who were on shift".

We looked at how the service managed risk. People had risk assessments in place which covered dependency, falls, nutrition, continence, moving and handling and pressure sores. Where people had been identified as being at risk, there were specific control measures in place to keep people safe. For example, people being weighed on a weekly basis if they had been deemed as at risk with regards to nutrition.

On the residential unit, several people's care plans often referred to the fact that it was important for the environment to be clear from obstructions so that they could move freely around the unit without falling. However, we saw that several hoists were left in corridors which presented the risk of people tripping and falling. We raised this with management who told us that they would look for a more appropriate place to store equipment in order to help keep people safe.

People were protected against the risks of abuse because the home had a robust recruitment procedure in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at five staff personnel files. Each file contained job application forms, interview notes, a minimum of two references and evidence of either a CRB or DBS (Criminal Records Bureau or Disclosure Barring Service) checks being undertaken.

We looked to see whether there were enough staff in order to meet people's care requirements. We looked at how the staffing levels were calculated and found that that the home was being staffed as to the number of people on each unit, but did not consider the dependency needs of people. We saw in the care files we looked at there was a dependency level calculator tool, which for some people was scoring as high. However these were not being brought together to inform staffing levels. This meant the service could not demonstrate that staffing levels reflected the needs of people who use the service.

This meant that at times there were insufficient staffing levels to offer the care required. The nursing unit was staffed by four care assistants and a lead nurse for the unit. This was to provide care for 23 people. Both the residential and dementia unit were staffed by two care assistants and a team leader working between the two units. There were 22 people living on the residential unit and nine people living on the dementia unit. An additional member of staff was working on the residential unit during the inspection, who had worked at the home previously in a student placement role but had not yet undertaken any formal training.

Through speaking with staff they felt staffing levels were not adequate, particularly on the residential and dementia unit. One member of staff said; "Staffing levels are very bad on here. With the team leader working between two floors, there is often only two of us down here. We are constantly playing catch up. Sometimes it can be absolutely chaotic. It really has an impact when we can't give people showers and baths when they want". Another member of staff said; "We need at least one more member of staff on the residential unit. There is at least five people who require assistance from two members of care staff. If there is only two of us here then others are left unattended. The team leader works between two floors so can't always be here". A third member of staff said; "Of the 24 people on this unit there are only four who don't have dementia. It's difficult to cope sometimes as their behaviours are so varied".

Through our observations on the residential unit, we saw that when two members of staff did attend to people who required assistance from both staff, that a new member of

Requires improvement

Is the service safe?

staff was often left to supervise people. This member of staff was working their first proper shift at the home and was shadowing the work of other care workers. As this member of staff had not yet done any formal training they would have been unable to assist people if they required support, for instance with moving and handling tasks, or if somebody was to fall.

We looked at the staff rotas. This indicated that only one member of staff worked on the dementia unit at night to care for nine people who used the service, of which the majority had been deemed as high dependency when assessed. One member of staff, who had worked on the dementia unit at night on their own, described how several people often had disturbed sleep and walked around the corridors, which could be challenging to manage. We raised our concerns about the current staffing levels to both the home manager and assistant operation director, who told us they would re-evaluate people's dependency requirements. These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

At our two previous inspections (April and October 2014) we found that medicines were not handled safely and we told the provider they must take action to improve the safe handling of medicines.

During this inspection we looked at records about medicines for 14 people. We saw there was some good practice around medicines handling, however we still found concerns about medicines safety for all 14 people. This meant that overall people were still at risk because medicines were not being handled safely.

Medicines were stored safely in a dedicated medication room, however on the day of our visit the door had been left unlocked. The room was immediately locked up when we informed the nurse that it was open. However, we saw that the keys were in the locks on the cupboards which meant that anyone gaining access to the room could have had access to medication. We found that creams were not stored securely in people's bedrooms and there were no risk assessments to show it was safe to do so. We found cream in one person's room which belonged to another person living in the home. After our inspection we were told that the risk assessments had been put in place.

During our inspection we saw there were arrangements to obtain medicines for most people. However we found that two out of the 14 people whose records we looked at had missed doses of their medicines because they were out of stock. One person had run out of their Paracetamol, for over four days, which meant they may have suffered unnecessarily from pain.

We saw that medicines were still not always administered safely. We saw that a system had been put in place to record the time some medicines, such as Paracetamol, had been given to people. However, we saw that nurses failed to take this into account and gave doses of Paracetamol too close together. If doses of medicines are given too close together people's heath may be at risk of harm.

At our last inspection we found that medicines which had directions to be given "before food" were not given at the correct times. At this inspection we found that medicines such as antibiotics were not given safely. If medicines are not given with regard to the manufacturers' directions they may not be effective or work properly.

We saw that one person refused doses of their regularly prescribed inhalers and food supplements for between five and six weeks. No records had been made to show that nurses had taken any action to protect their health caused by missing doses of their medicines.

At this inspection we looked to see if there was clear guidance and protocols for staff to follow to enable them to give people their medicines which were prescribed 'when required' or as a variable dose, safely and consistently. We found that there was not always guidance in place for medicines to be taken 'when required'. We found that some of the information in the protocols, in place did not give enough information to guide staff to administer medicines safely. We also found that some of the information to help staff apply creams safely was missing. However after our inspection we were told the information in the protocols for "as required" medicines and creams had been improved. We also found there was no information to guide staff about which dose of medication to administer when a variable dose was prescribed. People's health is at risk of harm if this guidance is not available.

We saw that one person needed to be given their medicines covertly. This is usually done by hiding medicines in food or drink. We saw although there was no information recorded with the Medicines Administration

Requires improvement

Is the service safe?

Record Sheets (MARS) to show that this person needed to be given their medicines in this way, or how to secrete their medication safely. We saw that this resulted in them missing half of some of their prescribed medicine which may have placed their health at risk of harm.

We saw that in order to be able to check that medicines were given safely there was a system of keeping a daily running total of the quantities of medicines was in place. However, when we used this information we found that not all medicines had been given as prescribed.

We saw prompt action was taken to ensure people were given their medicines safely when doses changed or medicines were stopped by the doctor.

The records about the administration were generally clear and showed what doses people were given and the stock levels in the home of medicines for each person. We found there was some good information recorded about how people liked to take their medicines .However we found the records about creams were not accurate because they were signed as applied by both nurses and care staff, but they were only applied by care staff. We found no records made about the use of prescribed thickening agents in drinks. We found there were some gaps on the MARS where nurses had failed to sign to confirm they had administered medicines. We also found on one occasion that the nurse did not complete the records at the time of administration which is a practice which could lead to errors being made.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

Requires improvement

Is the service effective?

Our findings

There was a staff induction programme in place, which staff were expected to complete when they first began working at the home. The induction is designed to give staff an overview of working within a health and social care environment and provide them with the skills and knowledge to care for people effectively. Each member of staff we spoke with told us they undertook the induction when they first commenced their role. One member of staff said; "I absolutely love this job. I did an induction when I first started at the home. I was given the opportunity to shadow other staff so I could see how things worked". Another member of staff said; "I did my moving and handling training before I began assisting people. It gave me a good introduction into working at the home".

We found that staff supervision at the home was consistent. We looked at a sample of staff supervision records which suggested that they usually took place 'every few months'. This provided managers with the opportunity to evaluate the performance of staff, discuss any training requirements and offer any suggestions for areas of improvement. We spoke with staff to establish if they felt well supported to undertake their work effectively. One member of staff said; "Very much so. There is always somebody there to help". Another member of staff told us; "There is enough training and support available definitely. I can go to anybody for advice".

We looked at what training staff had undertaken to support them in their role. Staff had a variety of training at their disposal including moving and handling, safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (MCA/DoLS), infection control and dementia. The majority of training was done through elearning and we saw that approximately five members of staff were not up to date in all of these topics and that the completion dates for these courses had now expired. We raised this with both the home manager and area manager who were aware of this and that a deadline of the 30th June had been given for completion before moving onto disciplinary procedures. We found that training for the remaining staff was up to date.

During the inspection we checked to see if the environment was suitable for people living with dementia and what adaptations had been made. We found these to be limited on the residential unit, where staff told us the majority of people lived with dementia. For example, there was no signage around the building which would help people correctly locate where the dining room or lounge area was. There also no memory boxes or things that people could touch and relate to as they walked around the unit. Additionally, things such as hand rails and toilet seats were not bright in colours and not all people's bedroom doors had their picture on which again, would make them easier for people to locate. The corridors on the unit were long and at times we saw people appeared confused about finding different rooms on the unit and asked where they were. We raised this with management, who told us they would look into installing appropriate signage around the unit.

We also looked at the environment on the dementia unit itself. Each persons bedroom had their name plate on the door and memory boxes on the wall outside their room, however the contents of the memory boxes would benefit from being made more specific to the each individual person. We found the home had made efforts to decorate the walls near to people's bedrooms with pictures and musical memorabilia from the 1950s. Other dementia themes adaptations included general signage towards the lounge areas and a display unit informing people what day it was and what the weather was like.

The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, with the least possible restrictions. Initially, there was some confusion about the number of people living at the home who were subject to a DoLS authorisation, as the manager had told us that at present, no applications had been submitted. It later transpired that two people who lived at the home were subject to a DoLS who lived at Pendleton Court. Through looking at the training matrix we saw staff had access to relevant training to further support them in this area, although through discussions with staff, their knowledge in this area was limited.

We looked at how staff sought the consent of people who lived at the home. Through our observations, we saw that

Requires improvement

Is the service effective?

staff did this before performing a particular case task. For example, at lunch time we saw that staff asked people first whether they would like to wear a bib or not to protect their clothing as opposed to simply placing one on them first.

Care plans on the dementia unit indicated that all people had been assessed for risk of malnutrition, including a Malnutrition Universal Screening Tool (MUST) assessment. We found that individual weights were being undertaken and monitored regularly, and that at the time of our inspection, nobody had showed any significant weight loss over time. Additionally, we noted that three people living at the home had gained weight over a sustained period. We found that fluid intake was recorded accurately and indicated a good level was being given to people living on the unit. This demonstrated to us that staff had a good knowledge of people's nutritional requirements.

During the inspection, we observed the lunch time meal on each unit to gain an understanding of how people were supported to eat their food. On the residential unit a 'light lunch' was served which consisted of soup, cheese on toast and a selection of different sandwiches. There was one person on the residential unit who needed full support to eat their lunch and we saw this task was undertaken by staff. Drinks of tea/coffee and juice were also offered and in general, we saw that people ate well and that the food looked appetising and well presented for people. Staff told us that some people required 'prompting' to eat their meals and again we saw this was provided for them whilst at the same time, promoting people's independence. For example, one person still had some soup left in their bowl and instead of doing it for them, a member of staff said; "Are you going to have a go first before I help you?". This promoted this person's independence.

We saw that the home worked closely with other professionals and agencies in order to meet people's care requirements. Involvement with these services was recorded in people's care plans and included Speech and Language Therapy (SALT), Dieticians, Chiropodists, District Nurses and Doctors.

Good

Is the service caring?

Our findings

The people who lived at the home told us they were happy living at the home. Comments from people included; "In general, I'm quite happy with the care here. They help me with a shower because I can't manage on my own" and "The care is very good. They help you with anything you want" and "On the whole they are very good to me here".

The relatives we spoke with were happy with the care being provided to their loved ones by staff at the home. One relative said to us; "My father was a broken man at the time he came to live here. I'm delighted my dad is here at Pendleton court. I've seen my dad emerge in the last 12 months and I couldn't ask for more. Superb support". Another relative told us; "Staff at Pendleton court should be very proud of their efforts". Another relative said; "Pendleton always feels like home when I come in". A visiting relative to the dementia unit added; "This is the best place for her. She has lived here for six years now and we couldn't ask for more".

During the inspection we saw that people were treated with dignity and respect by staff. The staff we spoke with were clear about how to treat people with dignity and respect when providing care. One member of staff said; "Some people need to be taken to the bathroom and I feel it is always important to clearly explain to them why they are going. If they need to use a pad, then again I try and explain what it is used for so that they are aware". Another member of staff said to us; "When it comes to dignity and respect, things such as closing doors, covering people during personal care and explaining what is going on is all very important". Through our observations, we saw that when entering people's bedrooms to provide personal care, staff closed the doors behind them to respect people's privacy.

During the inspection we observed that interactions were appropriate and friendly between staff and people who lived at the home. The relationship between staff and people's families were also noted to be warm, and had developed over a lengthy period of time. On the dementia unit of the home, there were lengthy periods of time when people were sat in the lounge with the television on, and nobody apparently watching it. Staff appeared to be completing records in the lounge areas but with minimal interaction with people living at the home. Several people on the units were sleeping for lengthy periods in armchairs, with no evidence of planned stimulation. We discussed this issue with the manager during feedback at the end of the inspection, who told us they would raise the issue with staff.

During the inspection we spent time observing how people spent their day and looked at the types of support people received from staff. We saw people being supported to walk around the building, assisted to the toilet when required, given their medication and assisted both to and from their chair. Staff spoke to people with respect and it became clear that caring relationships had been developed between staff and people who lived at the home.

We noted that staff explained any care intervention to people at the home. During the day, we observed staff assisting people with transfers, in several rooms around the home which tended to be from either their wheelchair into their arm chair, or from a hoist. During these observations, we saw that all were undertaken in a safe manner, and explanations were given by staff before movement. Some people living at the home required assistance from two members of staff and we observed that this was provided during any transfer that was undertaken.

We observed that people who lived at the home looked clean and well presented. People's care plans captured all aspects of personal care which had been delivered, such as if they had received a bath or a shower or if they had their hair brushed or their clothing changed. Additionally, where people were hard of hearing, we saw that staff crouched down at a similar level so that people could clearly hear what they were saying to them.

During the inspection, we saw that staff offered people choice. For example, we saw staff offering people choice of different food, drink or how they wanted to spend their day. One person living at the home said to us; "The staff help me get up in the morning which is something I need help with. They always offer me a choice of clothes and ask what I would like to wear". Another person added; "I choose to tidy my own room and make my own bed. Thankfully I can still do bits for myself but the staff respect that because it is what I chose to do".

Good

Is the service responsive?

Our findings

We saw several examples of where the home had been responsive to people's care needs. For example, one person who was required to be weighed monthly was noted to have lost a considerable amount of weight and immediately, staff referred this person to a dietician for further evaluation. Another person, who had been identified as at risk of potential dehydration was required to be given between seven and eight drinks throughout the day. We saw from looking at fluid intake sheets that these were provided at regular intervals by staff. Additionally, we found that people, as a result of advice from dieticians, were weighed on a weekly basis when required in order to keep them safe and meet their personal care needs.

We found that around the time people started living at the home, a pre-admission assessment was undertaken by staff. The assessment provided a focus on communication, behaviour, eating and drinking, dressing, mobilising, sleeping and elimination. This helped staff establish what people's care requirements were and how they could meet people's needs.

We saw that people then had care plans created which staff could refer to and provide care in line with people's requirements. Care plans provided a focus on capacity, challenging behaviour, daily routine, personal hygiene, toileting, eating and drinking, likes/dislikes, medication, mobilising and retiring to bed. We looked at a sample of care plans during the inspection and saw that were reviewed monthly, or in line with people's changing care needs.

We saw that surveys were sent to people who lived at the home and their relatives asking them for their views of the service provided. This asked people for their views about the care at the home, if people were happy, if they felt safe, privacy and dignity, activities and the general cleanliness around the home. Where any concerns or areas for improvement were suggested, they were then added to an action plan within the homes central database, with a deadline for completion. This demonstrated to us that the home were responsive to feedback in order to improve the quality of service to people.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of the service. We looked at the complaints file during the inspections and found that any complaints had been properly responded to, with a response given to the complainant. People told us that if they needed to complain they would speak to the home manager. The complaints procedure was available within the service user guide as opposed to being displayed in each of the units. We spoke with the manager about this, to ensure that it was in view of where people could easily make reference to it.

We saw that there was an activity schedule in place and we observed various musical therapy activities taking place, with the vast number of people taking part and appeared to enjoy. This was facilitated by an external activities person who regularly visited the home. On the day of the inspection, the weather was hot and we saw that people were encouraged to sit outside in the garden. Whilst this was being done, additional activities also took place which were facilitated by staff. One person living at the home said to us; "They always make a good effort here to keep us entertained".

We saw that meetings for both relatives and people living at the home were held at regular intervals to seek their feedback about the quality of service provided. There was an agenda in place which covered food, activities, staff attitude, laundry and cleanliness. We saw that people were able to voice their opinion about anything they wanted improve or make comment on. Again, where issues were raised, we saw they were added to the action plan within the homes data base with any necessary timescales for response. We saw various posters displayed around the home, informing people when the next meetings were due to take place.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager 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 staff we spoke with felt that the home was well run and managed. Comments from staff about leadership included; "I think the manager is very good. She is very approachable and fair. I feel I can also speak with her as a friend" and "The home is managed well. I like the manager. From what I have seen, I like" and "Fantastic. She's very helpful and approachable. Really nice as well".

The home manager conducted regular audits of certain areas within the home. These covered areas such as care plans and infection control. Where any areas of concern had been highlighted during audits, we saw there was a record of any action that had been taken to prevent them from happening again and potentially identify problems in advance. Additionally, the homes assistant operations director visited on a regular basis to conduct additional audits and was able to check the progress of any actions which had been, or needed to be taken through their central database.

We saw that there were also regular audits and checks made by senior management from HC-One in relation to medication. We saw the last audit was done on 1 June 2015 and three days prior to our inspection, stating that there was safe medicines management in the home. The audit failed to pick up the concerns we found during our inspection visit. This meant that the homes auditing processes were not always robust enough to identify concerns.

There were regular team meetings which took place at the home, between each of the different departments. These were attended by the manager, kitchen staff, maintenance staff, housekeeping/laundry, admin and senior care staff. Each department had been able to provide updates in relation to their individual areas as to how things could be potentially improved. Additionally, staff told us that they took part in daily handovers. This provided an opportunity to establish what had happened during the previous shift and gain a picture of how people who lived at the home were feeling on that particular day.

We saw that health and safety checks were undertaken regularly. There was a maintenance person who had a log of all jobs undertaken. We saw that they responded to any repair requests in a timely manner, carrying out small repair jobs themselves and bringing in outside contractors where necessary. There were records of, PAT (Portable Appliance Testing), fire alarm tests, emergency lighting checks and equipment checks. We saw that water temperatures were taken regularly and outlets flushed as necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 There were insufficient staffing levels at the home on the dementia and residential units, to meet people's needs in a timely manner

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Appropriate systems were not in place with regards to the proper, safe management of medicines

The enforcement action we took:
We issued a Warning Notice with regards to this regulation.