

Orchard Care Homes.Com (4) Limited

St Georges Hall and Lodge

Inspection report

Middle St George Hospital Site
Middle St George
Darlington
North Yorkshire
DL2 1TS

Tel: 01325335425

Date of inspection visit:
28 January 2016
29 January 2016
01 February 2016

Date of publication:
14 April 2016

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 28, 29 January and 1 February 2016. The inspection was unannounced. We previously inspected this service on 9 July 2014 and found the service to be compliant.

St Georges Hall and Lodge is a residential care home based in Middleton St George on the outskirts of Darlington, County Durham. The home provides care to older people and people living with dementia. It is not situated close to a town centre or close to any local amenities. Transport links to Darlington and Middleton St George village are close by. On the day of our inspection there were 62 people using the service.

The home had a temporary manager who at the time of our inspection wasn't registered. 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.

We spoke with a range of different team members; care, nursing, senior and kitchen staff who told us they felt well supported and that the manager although temporary, was supportive and approachable. Throughout the day we saw that people who used the service and staff were comfortable, relaxed and had a positive rapport with the manager and with each other. The atmosphere was welcoming, but very busy. We saw that staff interacted with each other and the people who used the service in a friendly, caring, positive manner.

From looking at people's care plans we saw they were written in plain English, using a tick box template throughout, not written in a person centred way, didn't include a 'one page profile' and didn't make use of pictures. Peoples' personal histories were missing from some of the care plans we looked at. They described individuals care, treatment and support needs and the daily record part of the plans were completed regularly and the care plans were regularly reviewed and updated by the care staff and the manager.

Individual care plans contained risk assessments. These identified risks and described the measures and interventions to be taken to ensure people were protected from the risk of harm. The care records we viewed also showed us that people's health was monitored and referrals were made to other health care professionals where necessary for example: their GP, community nurse or Chiroprapist.

Our observations during the inspection showed us that people who used the service were supported by sufficient numbers of staff to meet their basic care needs but not enough to be in a person centred way. The service used three different care agencies to manage staffing levels to cover sickness and vacancies and at times there were more agency staff than permanent members of staff.

When we looked at the staff training records they showed us staff were supported and able to maintain and

develop their skills through training and development opportunities. The staff we spoke with confirmed they attended a range of learning opportunities. However we found that some mandatory training wasn't up to date and staff needed to attend refresher training. Care staff we spoke with told us they had regular supervisions and appraisals with the manager, where they had the opportunity to discuss their care practice and identify further mandatory and vocational training needs. We also viewed records that showed us there were robust recruitment processes in place.

We observed how the service administered medicines and how they did this safely. We looked at how records were kept and spoke with the nursing staff and the service training manager about how staff were trained to administer medication and we found that the medication administering process was safe.

During the inspection we witnessed the staff rapport with the people who used the service and the positive interactions that took place. The staff were caring, positive, encouraging and attentive when communicating and supporting people.

People were encouraged to participate in activities that were planned in advance, including; bingo, crafts, music and singing. We saw staff spending their time positively engaging with people as a group on activities but not on a one to one basis with meaningful activities chosen by them. We saw evidence that people were being supported to go out and be active in the local community when it was possible but due to transport arrangements this was limited.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. We observed that drinks were available in some areas and in peoples rooms but not in others. We saw people were offered snacks at different times with drinks but there were no freely available snacks throughout the home for people to access. The daily menu that we saw offered 2 choices and it was not an issue if people wanted something different.

We saw a complaints and compliments procedure that was in place and this provided information on the action to take if someone wished to make a complaint and what they should expect to happen next. Although the complaints information poster on display on the notice board was out of date as all the staff named had left the service.

We found a quality assurance survey had taken place previously and we looked at the results. However there were no action plans attached to this or feedback for people who had taken part in the survey for example staff and relatives. The service had been regularly reviewed through an internal and external audits and there were actions identified that were on going to make improvements to the service. We saw that an action plan had been developed to improve the service and address issues found via the internal audits. We found people who used the service; their representatives were asked for their views at meetings but these had not been taking place recent months.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We found the service was working within the principles of the MCA. 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?

Good ●

This service was safe. □

There were sufficient staff to cover the layout of the building and the needs of the people safely.

The service provided sufficient staffing levels with the right skills mix and experience to keep people safe.

The service had an efficient system to manage accidents and incidents and learn from them so they were less likely to happen again.

Staff knew what to do when safeguarding concerns were raised and they followed effective policies and procedures.

Medicines were managed, and stored safely.

Is the service effective?

Requires Improvement ●

This service was not always effective.

Staff training was not up to date and needed refreshing.

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Staff training was not up to date and needed refreshing.

People's nutritional needs were met although there were mixed reviews about the food.

Staff were regularly supervised and received appraisals.

The service understood the requirements and principles of the Mental Capacity Act 2005 and put them into practice to protect people.

Is the service caring?

Good ●

This service was caring.

People and their families were valued and treated with kindness and compassion and their dignity was respected.

Care staff had access to advocacy services to represent the people who used the service.

People were understood and had their individual care needs met, including needs around age and disability.

Staff showed consistent concern for people's wellbeing. People were given the privacy they needed.

Is the service responsive?

This service was not always responsive.

People received care and support specific to their assessed medical needs but care plans were not person-centred and did not reflect their preferences, interests, and aspirations.

People and those that mattered to them were not actively involved and able to make their views known about their care, treatment and support.

Group activities were planned for people to take part in but none were person centred.

The service had a responsive complaints and compliments procedure in place and had received a range of compliments.

Requires Improvement ●

Is the service well-led?

This service was not always well led.

There was no registered manager in place at the service.

There were quality assurance systems in place to review aspects of the service including safeguarding concerns, accidents and incidents. Investigations into whistleblowing, safeguarding, complaints/concerns and accidents/incidents were thorough.

There was an action plan in place to implement improvements to the service from external sources but this did not include the views of staff, people who used the service or their relatives.

There were limited community links and no partnership approaches to tackling social isolation and inclusion.

Requires Improvement ●

St Georges Hall and Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 28, 29 January and 1 February 2016 and was unannounced. This meant that the service were not expecting us. The inspection team consisted of two Adult Social Care inspectors, a specialist advisor in nursing and an expert by experience in older persons' care. At the inspection we spoke with eight people who used the service, nine relatives, the manager, the office manager, the operations manager, three senior nursing staff, two kitchen staff, the maintenance worker, one member of domestic staff, one of the activities staff, six members of care staff and three members of agency staff.

We looked at eight people's care plans from across the service, five staff records and ten staff training records.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including the local clinical commissioning group and the local authority commissioners who were able to share their views with us.

Prior to the inspection we contacted the local Healthwatch and no concerns had been raised with them about the service. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work.

During our inspection we observed how staff interacted with people who used the service and with each other. We spent time watching daily routines to see whether people had positive experiences. This included looking at the support that was given by the staff, by observing practices and interactions between staff and people who used the service.

We also reviewed records including medication records, safety certificates, care plans and records relating

to the management of the service such as audits, rotas, action plans, surveys, minutes of meetings and policies.

Following our inspection we made contact with other care professionals who regularly visit the service and who were involved with the people who used the service and their care.

Is the service safe?

Our findings

People who used the service told us they felt safe living at St George's Hall and Lodge. One person who used the service told us, "Yes I'm safe here." Another told us, "There is a lot of agency staff and they are nice but a bit lost, you have to wait a bit at busy times for someone."

We spoke with the manager about staffing levels. They told us they were using a dependency model and explained how this was calculated on a weekly basis but that they brought in agency staff to cover annual leave sickness and current staff vacancies. They explained how the dependency tool worked out how many staff were required to care for people based on the numbers of people using the service and their needs. The operations manager also explained how using this tool had enabled them to identify the need for more staff. The manager had an action plan that highlighted recruitment as a main priority and that they were currently recruiting more care staff and nursing staff to reduce the amount of agency staff that they currently use.

We spoke with agency staff who were on shift during our inspection who told us, "I only pick up shifts for here and one other service, I love coming here." Another agency worker told us, "I have got to know the people I support here really well and I am here every week, I have worked in all the units and prefer this one best because I know everyone." A permanent member of staff told us, "Having agency can make things take longer but it's an extra pair of hands." The manager told us, "All agency staff work a 'supernumerary' shift shadowing other staff before they can work here and all agency staff are trained." The operations manager told us, "Our action plan around recruitment has the long term aim for us to reduce our use of agency to zero." This showed us that the agency staff knew the people well enough to support them safely and that the manager was taking steps to minimise any impact it may have on the service.

The service also had policies and procedures for safeguarding adults and we saw these documents were available and accessible to members of staff. This helped ensure staff had the necessary knowledge and information to make sure people were protected from abuse.

The staff we spoke with were aware of who to contact to make safeguarding referrals to or to obtain advice from. Staff told us that they had received safeguarding training within the last three years. They said they felt confident in whistleblowing (telling someone) if they had any worries. One staff member told us, "I would report any issues straight away to the nurse in charge or the manager."

The service had a Health and Safety policy that was up to date. This gave an overview of the service's approach to health and safety and the procedures they had in place to address health and safety related issues. We also saw that a personal emergency evacuation plan (PEEP) was in place for each individual who used the service. PEEPs provided staff and other professionals with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency.

We saw records of maintenance and monthly health and safety checks for the equipment used in the home to support this. We also saw records of other routine maintenance checks carried out within the home. These included regular portable appliance testing (PAT) checks of electrical equipment, water temperatures,

room temperatures and cold water storage. This showed that the provider had in place appropriate maintenance systems to protect staff and people who used the service against the risks of unsafe or unsuitable premises or equipment.

Regular fire alarm testing was carried out in the home and we saw this recorded along with fire door checks, fire alarm testing, escape routes, fire extinguisher checks and emergency lighting testing.

We looked at the arrangements that were in place to manage risk, so that people were protected and their freedom supported and respected. We saw that risk assessments were in place in relation to the people's needs such as nutrition, falls and skin care. This meant staff had clear guidelines to follow to mitigate risks. One member of staff told us, "If there is a risk for example someone wanting to use the stand aid then I would support this and speak to the nurse in charge."

We looked at the arrangements that were in place for managing accidents and incidents and preventing the risk of re-occurrence. The manager showed us this system and explained the levels of scrutiny that all incidents, accidents and safeguarding concerns were subjected to within the home. They showed us how actions had been taken to ensure people were immediately safe.

Staff files we looked at showed us that the provider operated a safe recruitment system. The staff recruitment process included completion of an application form, a formal interview, two previous employer references and a Disclosure and Barring Service (DBS) check, which was carried out before staff started work at the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helped employers make safer recruiting decisions and also prevented unsuitable people from working with children and/or vulnerable adults.

We discussed all aspects of medicines with the senior care staff and nursing staff, who demonstrated a thorough knowledge of policies and procedures and a good understanding of medicines in general. We saw that the controlled drugs cabinet was locked and securely fastened to the wall. We saw the temperature of the medicines fridge was regularly recorded and within recommended guidelines. We saw the medication records, which identified the medicine type, dose, route and frequency and saw they were reviewed monthly and were up to date. We examined the controlled drugs prescribed and a stock check; we found records to be accurate. This showed us that effective processes were in place to administer medicines safely.

During our observations of the medication storage and administration it was noted that two people were receiving medication covertly but only one of them had a best interests decision recorded in their care plan where family members and their GP were involved. This was highlighted to the senior staff who acted promptly to rectify this.

We observed the administering of medicines and saw that staff were professional in their conduct. The application of prescribed medicines, such as topical creams, was clearly recorded on a body map, stored in the Medication Administration Record (MAR) sheet and in the care plans. This showed the area affected and the type of cream prescribed. Records were signed appropriately indicating the creams had been applied at the correct times.

We saw there was evidence of sample signatures of staff administering medicines. There was also a copy of the home's policy on administration, and 'as and when required' medication protocols. These were readily available within the MARs folder so staff could refer to them when required. Each person receiving medicines had a photograph identification sheet, and preferred method of administration. On reviewing MAR documentation we observed no omissions of medicines. All medicines for return to the pharmacy were

disposed of safely in storage bins and recorded.

We found there were effective systems in place to reduce the risk and spread of infection. We looked at the cleaning schedules and found them to be up to date. We found almost all areas including the laundry, kitchen, bathrooms, sluice areas, lounges and bedrooms were clean, pleasant and odour-free. We noticed an area of corridor on the ground floor that did carry some unpleasant odour. This was pointed out to the manager who was aware of this and already had plans to replace the carpets in this area. At the time of our inspection the manager also told us that additional domestic staff were being recruited.

Staff confirmed they had received training in infection control and made use of protective clothing and equipment. Domestic staff showed us where extra supplies were kept and made available in the bathrooms. One member of staff told us, "We can get more whenever we want. It's all here and we tend to carry extra gloves on us anyway in case we need to grab them."

Is the service effective?

Our findings

During our inspection we looked at the ten most recent staff training records and could see in six of the records that some courses were out of date and needed refreshing. The training that had expired included manual handling, dignity and fire safety evacuation. When we spoke with the training manager they explained that the manager and the staff member would be alerted that they needed an update and therefore following their own procedures this should have been acted on.

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

For any new employee, their induction period was spent training and shadowing more experienced members of staff to get to know the people who used the service before working alone. New employees also completed induction training called 'skills for care' to gain the relevant skills and knowledge to perform their role. Staff had the opportunity to develop professionally by completing the range of training on offer. Training needs were monitored through staff supervisions and appraisals but some training was still out of date.

We reviewed the staff training files and these showed us the range of training opportunities taken up by the staff team to reflect the needs of the people using the service. The courses included; dementia awareness, medication, food safety and also vocational training for personal development and we could also see that staff had started their NVQ (National Vocational Qualification) Level two in health and social care. The training manager told us; "I come in and carry out observations with the staff to check their level of competency."

We saw staff meetings had taken place previously but none had been held for over 12 months. When we spoke with the managers they told us there were more meetings planned and there had been other staff meetings that they called 'flash meetings' but they were unable to produce the minutes of these meetings. When we spoke with staff members they did confirm that a meeting had been arranged and was imminent. The absence of staff meetings meant that staff were unable to come together collectively as a team to share ideas and discuss the support they provided to people and seek guidance provided by the manager in regard to work practices. However the staff records that we looked at showed us that individual staff members did have one to one supervision and appraisals.

Individual staff supervisions were planned in advance and the manager had a reminder system in place and a clear record of who had received their supervision. Appraisals were held annually to develop and motivate staff and review their practice and behaviours. From looking in the supervision files we could see the format of the supervisions gave the staff the opportunity to discuss any issues and also supported staff personal development.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. Throughout the inspection we observed people being offered a selection of drinks and snacks and support to have them if

needed. Drinks were also out in people's rooms and jugs of juice were out in most communal areas for people to access but not all. The menu that we looked at was balanced and offered two choices at every meal. We could see that if a person didn't want what was on the menu or even changed their mind that this wasn't a problem and other options could be arranged. The feedback we received regarding the food was mixed, one person who used the service told us, "The food is OK." Another told us, "My only complaint is the quality of the food. You look forward to your meals and they're a bit of a disappointment." One relative told us, "The food is not great, there aren't any healthy snacks on offer for people, like fruit."

The inspection team observed people who used the service having their lunch in all of the dining rooms. We saw members of staff interacting and supporting people where needed. The atmosphere in the dining areas was relaxed and the people who used the service were enjoying their lunch chatting to each other and the staff. We saw that staff were on hand to help people with their meal but people who needed assistance to eat had to wait their turn. When we raised this with the manager they were aware of this and assured us that they would be introducing plans to have more than one sitting at meal times to avoid this from happening. This meant the service needed to improve the mealtime experiences it provided to people who used the service, both in terms of ensuring people's likes and dislikes were incorporated into menu planning and in terms of ensuring their dining experience was a pleasurable one.

From looking at people's care plans we could see the MUST (malnutrition universal screening tool) was in place, completed and up to date. This enables care staff to assess if a person is at risk of malnutrition and then monitor what food they have and their weight. We saw that special diets were managed. For example people who required dairy free or people with diabetes had other suitable options available to them. We saw pureed and fortified food that had been prepared but wasn't presented attractively. The kitchen staff told us "We don't have thickeners to use or the moulds we need." This was brought to the managers attention who assured us that these would all be made available. This meant that there were improvements to be made regarding how the service ensured people who required a pureed diet could access and enjoy a pleasurable dining experience.

We saw that people's weight was managed and recorded regularly. Where supplements or other changes to diet were required this was also recorded individually. There were people receiving supplements and these were recorded effectively. When we asked the kitchen staff how they prepared different meals for individuals they said; "We add cream to food and buy in 'free from' foods for people who have allergies. We have a file to record people's allergies, likes and dislikes, but I've got to know people well and know what people don't like." The kitchen staff also showed us the planned menu and the choices for that day and how it was recorded. This showed us that the kitchen staff had knowledge of individual's likes, dislikes and nutritional needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

been submitted to the local authority and the manager understood their responsibilities with regard to DoLS. This meant the provider was following the requirements in the DoLS.

The Mental Capacity Assessment records we looked at confirmed that assessments had been carried out regarding people's capacity to make particular decisions. We also saw records of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

We discussed DoLS with the manager who was aware of their responsibilities with regard to DoLS. We saw staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This meant the provider was following the requirements in the DoLS.

During our inspection we noted some people had their own brightly coloured front door, which was clearly numbered. Some people had photos of themselves or family members beside their door and others didn't. The lounge areas and hall way were not brightly coloured to help people with dementia navigate independently to their room and around the home. The walls in the hallway on the ground floor displayed historic street names of the town and objects attached to the walls to provoke memories. The crockery was also brightly coloured so that it was easy to see. Although some efforts had been made to make the service more 'dementia friendly' it wasn't consistent. During our inspection we observed the same two people on three occasions unable to find their own rooms. This meant that although some attempts to improve the environment for people living with dementia had been made there was no consistency to this approach.

When we spoke with staff about the environment they told us "We did have photos and names on doors previously but they were pulled down by people and not replaced. We have talked about making memory boxes to display outside peoples doors, we can revisit this." When we spoke with the manager he told us how there were plans in place to improve the decor especially in the hallways to make them less neutral and more dementia friendly.

Where possible, we saw that people were asked to give their consent to their care, before any treatment and support was provided by staff. Staff considered people's capacity to make decisions and they knew what they needed to do to make sure decisions were taken in people's best interests and where necessary involved the right professionals.

We saw records that showed us a wide range of community professionals were involved in the care and treatment of the people who used the service, such as community nursing teams, chiropodists and the speech and language therapy. Evidence was also available to show people were supported to attend medical appointments and was this clearly recorded in peoples care plans.

Is the service caring?

Our findings

When we spoke with the people who used the service they told us, without exception, that staff were caring, supportive and helped them maintain their independence. One person who used the service told us, "Oh they are nice to me, the girls." Another told us, "The staff are pretty good to you and my visitors can come in whenever they want."

We saw staff interacting with people in a positive, caring and professional way. We spent time observing support taking place in the service. We saw that people were respected by staff and were treated with kindness. We observed staff treating people in a caring way. We saw staff communicating well with people and enjoying activities together. When we spoke with relatives we asked them how the staff treated them and their relatives. One relative told us, "They look after my relative very well; the girls are very kind, no worries about that, they look after them very well."

The staff we spoke with explained how they maintained the privacy and dignity of the people that they cared for at all times and told us that this was an important part of their role. One member of staff told us, "We always make sure the curtains are closed and doors are closed when supporting people with personal care in their rooms." We observed staff supporting people to their rooms discretely and this meant staff respected people privacy and dignity.

Throughout the inspection the care staff were busy but still relaxed with the people they were supporting. We found the staff were affectionate and people were treated with dignity and respect and privacy was important to everyone. We spent time observing people in the lounge, dining areas and their rooms.

We saw that there were posters on display for visitors and people who used the service to explain how they could access support from an advocate, as well as relevant contact details. This meant people who used the service had access to others who could act on their behalf and in their best interests.

During our inspection, we saw in people's care plans that people were given support when making decisions about their preferences for end of life care. In people's care records we saw they had made advanced decisions about their care regarding their preference for before, during and following their death. This meant people's physical and emotional needs were being met, their comfort and wellbeing attended to and their wishes respected. At the time of our inspection there was no one in receipt of end of life care.

During our inspection, we saw in some people's care plans that people were given support when making decisions about their preferences for end of life care. In two people's care records we saw they had made advanced decisions about their care regarding their preference for before, during and following their death. This meant people's physical and emotional needs were being met, their comfort and well-being attended to and their wishes respected.

We saw examples of compliments sent in by family members after the loss of their relative that were complimentary and offering gratitude for the care given to their relative and family at that difficult time.

This showed us that the service assured people receiving end of life care that staff would always treat them and their family with compassionate care, sensitivity and respect.

We saw records showed that a wide range of community professionals were involved in the care and treatment of the people who used the service, such as community nursing teams, dieticians, chiropodists, speech and language therapy team and medical practitioners. Evidence was also available to show people were supported to attend medical appointments. This helped to ensure people's health care needs were being met.

Is the service responsive?

Our findings

Of the eight care plans that we looked at none of them were person centred and were not in an accessible format. The care plans did give details of the person's care needs and risk assessments. They were presented in a tick box format and focused mainly on care tasks. The care plans didn't give an insight into the individual's personality, preferences and choices and seven of the plans didn't contain any history information about the person or their likes and dislikes. We found this focus on tasks and medical needs was a consistent theme throughout care planning and the service had not ensured people's individual preferences with regard to meaningful activities were met.

This was a breach of Regulation 9 (Person – centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some activities available for when the activities co-ordinator was not available but not all staff or relatives we spoke with knew about these and there were no clear guidelines for staff regarding this. Although we established that activities took place, they were not responsive or individualised and only for people who were able to take part in group activities. Staff acknowledged the issue. The service had two activities co-ordinators who between them provided group activities seven days a week. We spoke with one of them who told us that activities that were planned in advance and they told us how they struggled at times to engage some people in activities on a one to one basis and that activities were mainly done on a group basis. They told us "It's hard. I go to people's rooms after breakfast and let them know what's on and see who wants to get involved." It was apparent that some people who used the service would value a more one to one approach to activities and lots of encouragement to engage and this was not available for them. One member of staff told us "[name] can be challenging and it's hard to get them involved, I don't feel like we can sometimes."

During the inspection we could see there were group activities in place and we witnessed some people engaging in activities. We were able to talk with people about the activities and one of the people using the service told us "I do the garden in better weather, my wife comes in and helps." we saw people enjoying an ad hoc activity of a pub lunch in the activity area that had a bar. We also saw that people who were able to were making Chinese lanterns for the upcoming Chinese New Year. Other activities that were planned included; bingo, hairdressing, pamper days and quizzes.

When we asked the staff if they knew how to manage complaints they told us, "I would go straight to the Nurse in charge or the manager if I had a complaint." A visitor at the service also told us that they knew how to raise issues if they needed to although the complaints information on display was out of date. One person who used the service told us, "I would go to the manager." When we looked at the complaints and compliments we found that they had been dealt with appropriately and outcomes were recorded.

A handover procedure was in place and we saw the completed record that staff used at the end of their shift. Staff said that communication between staff was good within the service. The handover covered each

person and included their daily patterns as well as any wellbeing issues, visits or appointments and was clearly recorded and complete. This showed us that communication between shifts was in place.

Is the service well-led?

Our findings

At the time of our inspection visit, the home didn't have a registered manager. A registered manager is a person who has registered with CQC to manage the service. The service had a temporary manager in place that had been at the service for 3 weeks but was not registered.

The staff members we met with told us that they thought the manager in place had made some improvements in their short time at the service and that they were positive about them. One member of staff told us "They seem approachable." and one relative told us, "Since the temporary manager has come some of the issues have been addressed." Another told us "To be fair things are improving now."

The service had a vision and set of values. The manager told us "The values are to always promote independence and to make sure we always meet people's needs and that people are stimulated."

During our inspection we spoke with the staff and the manager about how links with the local community were made as the service was situated in an isolated location. The manager and staff told us that the service had church services twice a month but that other visits to the local community were very limited due to transport arrangements and available staffing. When we asked the manager and staff if there were efforts made to engage with the local community and make links with the local village community there was a mixed response and the manager was unable to provide any evidence or future plans to develop good community links. Therefore the service's ability to protect people from social isolation was limited.

We saw there were clear lines of accountability within the service and external management arrangements with the provider. We saw quality monitoring visits were carried out by the provider and these visits included the following; staffing, medication, health and safety, staff training and supervision, facilities and consent. The manager also carried out quality assurance checks and had an action plan in place to address issues raised from their own findings and from the provider.

We saw there were arrangements in place to enable people who used the service, their representatives, staff and other stakeholders to have their say in the way the service was delivered. For example, the service had a quality assurance and quality monitoring questionnaire in place. These were based on seeking the views of people who used the service, their relatives, friends and health and social care staff who were involved with the home. Although the questionnaires had gone out and the results were collated they were not on display and there were no plans in place to act on the comments received or to offer feedback to the people who took part. The manager assured us that this would be carried out and the feedback would be acted upon as part of the quality assurance action plan already in place. Staff told us that staff meetings did not take place on a regular basis but that they were encouraged by the manager to share their views within their supervisions. We saw records to confirm this. We could see that the manager had planned a future staff meeting and the staff confirmed that they were aware of this.

When we spoke with the manager he told us how focussed he was about improving the service and

supporting his team and how the main focus was to recruit a permanent manager to carry on the improvements and recruit more staff to reduce the use of agency staff.

The manager showed how they adhered to company policy, risk assessments and general issues such as trips and falls, incidents, moving and handling and fire risk. We saw analysis of incidents that had resulted in, or had the potential to result in harm, were in place. This was used to avoid any further incidents happening. This meant that the service identified, assessed and monitored risks relating to people's health, welfare, and safety. We saw the system for self-monitoring included regular internal audits such as accidents, incidents, building, fire safety, control of substances hazardous to health (COSHH), fixtures and fittings, equipment and near misses.

We saw all records were kept secure, up to date and in good order, and maintained and used in accordance with the Data Protection Act. All the policies and procedure we looked at had all been recently reviewed in 2016.

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 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 9 HSCA RA Regulations 2014 Person-centred care |
| Diagnostic and screening procedures | Care plans did not reflect the peoples preferences and were not person centred. Regulation 9(c). |
| Treatment of disease, disorder or injury | |

| Regulated activity | Regulation |
|--|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing |
| Diagnostic and screening procedures | Staff didn't have up to date training to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a). |
| Treatment of disease, disorder or injury | |