Akari Care Limited

Comfort 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The unannounced inspection took place on 4, 6 and 8 September 2017. We last inspected Comfort House in June 2015 when we found the service was in breach of Regulation 18 in relation to staff not receiving adequate supervision and yearly appraisals.

At this inspection, although all appraisals were not yet complete, the new manager had made improvements to ensure that staff received appropriate support and had planned to have the remaining appraisals completed in the near future. Staff had received supervision sessions to allow them the opportunity to discuss a variety of issues and development opportunities.

Comfort House provides residential care for up to 42 people, some of whom are living with dementia. At the time of our inspection there were 38 people living at the service.

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

People received their medicines in a timely manner, however we found areas of concerns which needed to be addressed. We found thickeners which had been left in an unlocked room which posed a risk to people. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. We also found medicines security, storage of unwanted medicines and staff not using information they had available regarding 'as required' medicines was of concern.

We found that moving and handling procedures were not always being carried out correctly which posed a risk of harm to people.

Maintenance of the home was undertaken, although recent lift failures had resulted in one person (unharmed) being trapped in the lift. We have been given reassurances that the lift was in the process of having some major repairs completed.

Staff were aware of their personal responsibilities to report any incidents of potential or actual abuse to the manager.

People told us there were enough staff at the service to support them and we confirmed this through viewing records, however, the use of agency staff had impacted on the day to day support given. The provider had recently recruited more care staff and they were due to take up their posts in the coming weeks.

We found call bells were sometimes slow to be answered. Call bell monitoring was difficult to undertake, because the system did not allow monitoring reports to be completed. The provider told us they were about to install new software to address this.

We found emergency procedures, including fire safety were monitored and staff knew what to do in an emergency. Accidents and incidents were recorded and monitored to identify any trends. The premises was not always as clean as it should have been. The manager confirmed after our feedback that they took action to rectify this, including deep cleaning, contact with infection control specialists in the area and appointing a new infection control lead.

We received mixed views from people on the quality of the food available. We found that kitchen staff did not have all the information they should have regarding people's dietary needs. However, from observations people still managed to be provided with suitable diets appropriate to their needs. The manager dealt with this issue immediately.

We found staff were adequately trained. They received induction and supervision. Appraisals were being completed and there was a plan in place to ensure all staff received one this year. The provider followed safe recruitment procedures in order to ensure that staff employed were suitable to work with vulnerable adults. We noticed the provider had recently audited staff files and renewed some DBS checks.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes. In England, the local authority authorises applications to deprive people of their liberty. We found the provider was complying with their legal requirements.

People told us staff were kind and cared for them well, however, through our observations this was not always the case. We saw on occasions people were not always treated with dignity and respect and some staff did not show consideration when supporting people, including the use of the word 'please'.

Care was planned and person centred with associated risk assessments in place to keep people safe.

We found audits and checks were in place which helped the manager to monitor the quality of the home and had supported the provider to make a improvements since January 2017, however, issues that we had found were not always highlighted through these checks.

Relatives told us they liked the manager and the staff team and thought the service had better leadership than previously as things had improved. Staff told us they felt supported by their colleagues and the manager, although some staff felt that staff morale needed further improvement. Some staff indicated a divide between night and day staff; we discussed this comment with the manager who said she would look into this issue.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment and good governance.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines management needed to be improved. Moving and handling procedures were not always completed in line with safe practice.

The premises was generally well maintained, however, the lift was in need of major repair work which was due to be commenced.

Other risks had been identified and managed appropriately. Accidents were recorded and monitored. Staff were aware of their safeguarding responsibilities and knew what to do if they had any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective

We had mixed views on the range of food available. Kitchen staff did not always have up to date information on people's dietary needs.

There were induction and training opportunities for staff and staff told us they were supported by their line manager.

The manager and staff had an understanding of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People and their relatives felt involved in the service and how it operated and information was available throughout the service.

We were not made aware of any person using advocacy services as people generally had family or friends who supported them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People participated in activities although further improvements needed to be made.

Records reflected people's individual needs. Care plans were reviewed and updated. People were able to make choices in their day to day living.

People and their relatives told us they knew how to complain if needed and information was available to support them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits and quality checks were completed and monitored by the provider and the manager, although the issues we found during the inspection had not been identified or identified as still occurring.

Relatives told us they liked the manager and the staff team and improvements had been made in recent months. Meetings were held to gain the views of users of the service in order to improve quality.

Staff felt supported but felt morale needed to be further improved, with some staff saying they felt there was somewhat of a divide between day and night staff.

Comfort 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 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 4, 6 and 8 September 2017 and was unannounced. The inspection was carried out by one 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.

Prior to the inspection we reviewed information we held about Comfort House, including any statutory notifications of incidents occurring that the provider had sent us and any safeguarding information we had received.

Prior to the inspection we contacted the local authority safeguarding and commissioning teams, the local fire and rescue service, infection control colleagues and local Healthwatch staff.

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

We spoke with 12 people who used the service and eight relatives or visitors. We spoke with the manager, deputy manager, three senior care staff, five care staff, the cook, a kitchen assistant, the administrator, two staff from the domestic team, the maintenance person and two agency staff.

We observed how staff interacted with people and looked at a range of care records which included the care and medicines records for six of the 38 people who used the service and recruitment records for six staff. We looked at staff rotas, maintenance records, health and safety records and information, quality assurance checks, complaints and compliments, activities information, handover information and other documents related to the management of the service.

During the inspection we spoke with a GP and a district nurse who was visiting the service. We also contacted two social workers and one care manager.

Requires Improvement

Is the service safe?

Our findings

In 2015 NHS England issued an alert which was distributed to care homes. It was made to make them aware that a person had died in a care home following ingestion of a thickening powder. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. During the inspection we found a container of thickener on a shelf in the unlocked hairdressing room. We immediately pointed this out to the manager who had the item removed and the room locked. The manager told us that this room had been temporarily used while lift repairs had been completed and apologised stating it would not happen again.

The service used an electronic medicines management system. We noticed that not all 'as required' medicine details were recorded on the electronic system which staff used as they administered people their medicines. 'As required' medicines are medicines used by people when the need arises; for example tablets for pain relief used for headaches. There was however, full detailed information held within a file kept in the medicines room. We spoke to the manager about this and we saw the file with this information was then transported with the staff member as they completed their medicine administration 'rounds'.

Room temperatures were checked and secure storage facilities for all medicines were available. However we found staff did not always lock medicines trolleys, including those which held topical creams. Topical medicine refers to, for example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. We also found topical applications left unsecure in a box on the ground floor. The medicines trolleys were also found not to be secured to the wall in the medicines room at all times.

When administering medicines to the correct person a picture of the person should be available to ensure staff are dealing with the correct person. We found one person where this was not the case. We checked records and found they had admitted to the service in July 2017 which gave staff two months to put this in place.

We found that medicines which needed to be returned to the pharmacy were not in a tamperproof container and stored as per The National Institute for Health and Care Excellence (NICE) guidelines. NICE is an organisation called The National Institute for Health and Care Excellence. They provide national guidance and advice to improve health and social care.

The moving and handling of people was not always completed in a safe way. During the inspection we observed occasions where staff did not follow best practice procedures for the moving and transferring of people. This included using a toileting hoist inappropriately. We reported this immediately to the manager who, together with the deputy manager reviewed process and carried out spot checks on staff. The spot checks highlighted some areas of improvement with particular staff. The manager confirmed that additional training had been organised and was to take place imminently. She also told us that where issues had been highlighted, these staff would be closely monitored. Also stating staff identified would be in pairs with experienced staff for any transfers and that further spot checks would be completed to ensure that safe moving and handling practices were followed. However, on day two of the inspection we observed a further

example of poor practice when staff moved one person from a chair to a wheelchair.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views from people and their relatives about how safe they felt. People told us they felt safe with staff and felt protected, however a number of people commented on how unsafe they felt using the lift in the home. Comments included, "I worry every time I get in here, in case it breaks down"; "Workmen came into fix the lift, you get frightened to get in that thing, I wish they would just put it right" and "To my knowledge it's (lift) been broken seven times and it's no good for the people who live upstairs." Other comments included, "Yeah it's alright, I'd rather be at home though, but the staff are very good, I couldn't fault them at all" and "Yes, everything is fine here." Relatives comments included, "[Person] moved in last X and [person] has settled in well. I know [person] is well looked after otherwise I would move [person] out. I know a few of the staff have changed but [person] has never said anything bad about any of them"; "Oh yes, absolutely (safe)"; "Yes, safe and well looked after, the staff say that they would have 100 of her" and "Safety is important and I have no qualms about that."

We viewed the maintenance records for the lift and saw that eight call outs were recorded between 18 May 2017 and 1 September 2017. There had also been a number of repair visits and the mandatory full examination of the lifting equipment had taken place. We also discovered through conversation with one relative and looking at incident records, that a person had been trapped in the lift. The manager told us that although it had been distressing for the person and as a precaution they had summoned emergency services, the person had not come to any harm and North East Ambulance Service confirmed this to be the case. We contacted the provider to gain assurances that the concerns over the lift were being addressed. They contacted us and confirmed that a quote had been received for work to be completed.

Further cleaning and tidying was required and we found that, communal rooms not regularly used, were not as clean as they should have been. We also on one occasion saw staff entering the kitchen area without suitable personal protective equipment, such as aprons. We spoke with the manager about our concerns and they said they would address the issues raised immediately.

When we spoke with staff, they had an understanding of safeguarding procedures which included how to protect people from harm. Staff confirmed their training in this subject had been completed and we were able to confirm this from their training records. One member of staff told us, "I would have no hesitation what so ever to report anything."

Risks to people's safety had been assessed by staff and records of these assessments had been reviewed. Risk assessments had been personalised to each individual and covered areas such as falls, nutrition, pressure areas, choking and moving and handling. We were made aware that one staff member was pregnant but could not see a risk assessment to protect them from harm. From speaking with staff they were aware of their limitations and how to keep themselves safe. We mentioned this to the manager who said she would put one in place.

The premises was generally well maintained with a number of system and equipment checks taking place, including those in relation to fire safety, gas and electricity.

During the inspection we found call bells were not always responded to as quickly as they should have been on occasions. We asked to see reports of the call bell activations and timings to confirm that people were being responded to in a timely manner. The provider was unable to provide us with this information and

told us they needed to purchase additional software in order to be able to extract this data. They confirmed that the software was going to be installed week commencing 16 October 2017 to allow them to monitor the situation.

The manager told us they had a system to assess people's needs and dependency levels which was used to devise the staffing rota. Sufficient staff were on duty according to their calculations on the days of the inspection. However, due to staff shortages, agency staff were being used. The consequence of this was that at times support provided to people took longer to deliver. People told us they felt there was enough staff, although alluded to them being busy at times. One person told us, "They [manager] could do with a few more [care staff] at times, they get so busy." Another person said, "It varies, sometimes okay but sometimes not." The manager told us regular agency staff were used where possible but they had recently appointed new care staff and were waiting for checks to be confirmed and agency usage would reduce.

During the inspection we sat in at handover to observe how information was shared between the staff teams. We noticed that agency staff arrived at the end of the handover. Two permanent members of staff confirmed that it was rare for an agency worker to arrive soon enough to be present at handover. This meant they did not receive all of the pertinent information about individuals and there was a risk of people's needs not being fully met. We brought this to the attention of the manager who said she would look at agency induction, including handover procedures and ensure they were more robust.

We viewed the recruitment records of six staff, including those recently employed. We found the provider had requested and received references, including one from their most recent employment. We saw application forms and notes from the interview process. A disclosure and barring service (DBS) check had been carried out before staff took up their position.

Requires Improvement

Is the service effective?

Our findings

At the previous inspections in June 2015 we rated this domain as Requires Improvement. We had identified a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to Staffing. Staff supervision and annual appraisals had not been adequately undertaken. At this inspection we found the provider had taken action to address this issue and although not all appraisals had been completed, these were planned to be completed in the near future.

People who lived at the service and their relatives told us they felt staff were able to support them with their care needs. One person told us, "Staff know what they need to do to help me." Another person told us, "Some staff are better than others, but they help with what needs done."

When we asked one relative if their family liked living at the service, they told us, "Yes I think so, sometimes it's hard to tell as [person] has dementia, but [person] moved in nearly X years ago so I think we would know if [person] didn't."

On the first day of the inspection, the meal time experience was somewhat disorganised. Although meals were kept hot, a number of people waited an additional hour for meals to be served in their bedrooms or in other communal areas. We also noted that one particular person who was living with dementia was left unattended with their meal. Their care plan clearly indicated that staff should support and encourage them with their meals. The same person was given snacks during the day, and we observed them to be left with the snack and no encouragement offered. The snack was left uneaten until we sat next to the person and reminded them of the food in front of them. However, day two and three of the inspection was not the same and people received their meals in a timely manner with suitable support in place.

We received mixed views on the food prepared at the service, although we were aware that there had been recent changes with the staff working within the kitchen. Comments included, "Yes I enjoyed it [lunch], but sometimes you get the same run of the same type of things and you get a bit sick of them. Some of the fruit is too hard to"; "It's [meals] nice enough, you cannot please everyone all the time, but they do try"; "It's [fish] a bit hard, not to my taste"; "Food is canny [nice]" and "Food looks okay but I know that sometimes [person] leaves it because it is not always to their palate"; "Food is better than it was, and I know they [manager] are looking for further ways to make it even better."

People were not always aware of what was going to be served at meal times. One person told us, "I've no idea (menu choice), but the meals are very good. I've never noticed anyone complain about anything." Another person told us, "I get asked what I want but sometimes forget, not seen a list anywhere to look at." We saw a four week menu displayed near the entrance to the dining area, but three people we asked had not realised it was there.

When we visited the kitchen we found that staff did not have up to date details of all people's food preferences or dietary needs, although this information was available in people's care records. We observed how kitchen staff managed to ensure all people had the correct food served to them without this

information for a small number of people. We confirmed that people had their dietary needs met, and did not receive food which they should not have. The provider, however, ran the risk of an error occurring because information was not up to date. We discussed this with the manager who said they would address this straight away.

We recommend the provider ensures that kitchen staff have full details of people's preferences and that menus are clearly displayed in a suitable format.

Refreshments were available throughout the day and we observed people in their bedrooms being supported to remain hydrated. Relatives commented on how there had been improvements in snacks and refreshment breaks in between meals with timely scheduling of the tea trolleys.

We asked staff about their induction. They confirmed the manager had followed the provider's induction procedures which included shadowing more experienced members of the team. The provider also followed the Care Certificate standards to ensure staff were supported with best practice procedures. Staff told us they felt supported by the team they worked with and also by their line manager. Staff confirmed they received regular supervision now and records confirmed this. Supervision is when staff meet with their line manager and discuss their role and responsibilities. Staff appraisals were now being completed by the manager. She explained that she had made good efforts to get these completed, but had not managed them all. The remaining staff appraisals had been planned to take place. This meant the provider had taken steps to ensure staff were supported in their roles.

Staff told us their training was either up to date or ongoing. The manager told us if additional training was needed, the provider would support staff to meet their training needs. For example, one member of staff confirmed they were undertaking a management training course to enhance their performance. We viewed staff records, training certificates and the providers training matrix and found that a range of training had been undertaken, which included, medicines administration, safeguarding vulnerable adults and health and safety related training. There were a number of refresher courses about to take place and the provider confirmed that they had recently reviewed their training programme and a new training provider had been appointed. We spoke with agency staff during the inspection and they were able to confirm the training they had received prior to working at the service. We checked this information with their records and confirmed as correct.

Competency checks were completed with staff to ensure they were performing their caring duties to a satisfactory standard. We found a small number of gaps in competency checks with staff. We brought this to the attention of the manager who said she would look into this.

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.

The manager told us there were currently three people living at the service who were subject to a DoLS authorisation. We saw the service maintained appropriate paperwork in relation to this. We saw copies of

capacity assessments and evidence that best interest decisions had been made with appropriate people involved, including GP's and family members. We observed staff asking for consent, for example, during medicines administration and when people requested support with personal care.

We noted the provider did not always have copies of Lasting Power of Attorney (LPA) documentation, although records showed that these were in place. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. We spoke with the manager about this and she agreed that she would contact relevant families and gain copies of this documentation. She later confirmed she had written to all families/carers involved.

People had access to external healthcare professionals to monitor and support their general health and well-being. We saw communication and visits from specialists recorded in people's care plans, including GP's, district nurses and eye care professionals. One healthcare professional told us, "The home appears to be proactive in getting the appropriate professionals involved when it is needed." A visiting GP told us, "Staff seem to know what they are doing. I am not aware of any inappropriate referrals." Another healthcare professional told us, "Communication is good, it is much much better than it used to be."

The premises had been adapted to fit the needs of the people living there. For example, doors were wide enough to allow wheelchair access and hoists were available for those people who required that level of support. The outside area was fully accessible with a small lawned area, some raised beds with benches and tables for people to sit. We noted that the garden, however, was not secure and had a number of uneven surfaces. We spoke with the maintenance person who told us that he thought work was planned in the future to rectify these issues. We noted that the issue of uneven surfaces had been raised with the provider a number of times, including on 14 December 2016. We brought this to the attention of the manager who confirmed work was planned. We also noted that some signage was required to better promote the orientation of people who were living with dementia. This included bedroom door signs, pictures and names. We were made aware by the manager that work was ongoing in the service, including a full refurbishment of rooms and would be completed as part of that. We viewed one of the bedrooms undergoing a refurbishment and found new ensuite facilities had been installed and bedrooms fully redecorated with the plan of new carpets and other soft furnishings.

Requires Improvement

Is the service caring?

Our findings

Dignity and privacy was not always maintained by the staff team. During the inspection we heard one staff member shout across the communal lounge area to another staff member that they had a person on the toilet waiting for them.

We overheard a conversation taking place between a staff member and a visitor to the service in connection to a person's health and information was given which was of a confidential nature. We brought this to the attention of the manager who said she would address this with the staff team.

Staff did not always speak with people in a courteous manner, and the use of the word 'please' was sometimes not used when asking people to help them to provide care. Examples of this included, when asking one person to put their arm in a sling or with another person when staff wanted them to move their leg.

We completed a number of observations over the three days of the inspection. We found not all staff appeared to have a good understanding of how to manage people's behaviours that challenged the service and did not always communicate or engage with people when the opportunity presented itself. For example, during transfers or while staff were passing. We observed one person who was living with dementia had no stimulation or interaction with staff for over an hour and a half even though staff had passed by the area in which they were sitting. On another occasion we observed the same person shouting out and saw that not one member of staff spoke to them to offer reassurance. We overheard one person talking to another saying, "I wish they [care staff] would talk to [person], that would make them be quiet. I am fed up with it." We sat next to the person and quietly offered some reassurance with the result being that the shouting subsided. We noted that the same person used doll therapy as a means to comfort them. However, during the course of the three days we saw no doll offered. We discussed this with the manager who said they would look into this.

Other observations found staff interactions with people extremely positive. One staff member supported an individual with a meal. The staff member remained in eye contact and spoke to the person throughout. On other occasions we overheard staff treating people with compassion and kindness. For example, one staff member was overheard saying, "You have done a good job of that [person's name] (meaning they had accidently spilled some food on themselves). How do you feel about me helping you? Got to look your best now haven't we!" Another member of care staff was overheard saying, "Hello [person's name] and how are we today?" When the person replied we then heard some chuckling coming from their room. A further staff member was heard offering reassurance to one person who was concerned about their weight. The staff member said, "You've put a little bit of weight on [person's name]. You're just a worrier! (they both laughed)…why don't you sit and relax and try not to worry."

People told us they liked the staff team and felt well cared for. Comments included, "I get along with them all fine, they're all lovely to me"; "They [care staff] are wonderful; I can't complain"; "He is lovely [deputy manager] for a man! (and laughed)" and "It's alright but I don't like it", We asked why, and the person said, "I

just want to go into my own home." Relatives told us, "Yes we know she is well looked after, she's always kept clean and tidy, they keep a good eye on her skin too as she can have problems"; "We think the staff do care" and "I do believe the staff are kind and caring" but also said, "I am just not always sure there is enough."

One healthcare professional we spoke with was complimentary about end of life care provided at the service and gave us an example. They said staff had gone out of their way to "provide the best possible care at a very sad time".

We saw lots of 'thank you' cards from people's families and friends who remarked on the care and kindness shown by all staff at the service.

People were supported to maintain their independence. We observed people being encouraged to mobilise and staff prompting people to eat their meal in dining areas and other areas, including bedrooms. People who were able to mobilise were free to move around the service and were able to sit where they wished.

During the inspection representatives from a local church visited to provide people with spiritual support and guidance. We were also told by staff that anyone wishing to receive support from another denomination could be arranged for them if it was not already in place. We noted information on notice boards gave details to people and their relatives about when visits were to be made.

Information about advocacy services was available but at the time of the inspection we were told that no one living at the service was using an advocate. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. The majority of people used their relatives or friends for support, but staff knew how to access additional support if it was required.

Notice boards at the service and a table in the reception area had information on them to keep people and their relatives or visitors up to date. For example, there was information on CQC inspections, complaints policy, details of a relatives meeting, hand hygiene information and activities taking place.

Requires Improvement

Is the service responsive?

Our findings

Care records were mostly up to date and contained detailed information to support staff in helping them to provide tailored care that met the needs of the people who lived at the service. This included a pre-assessment of an individual's needs before they came to live at the service and then a more detailed set of care plans which were used to support staff to address the person's identified needs. Care plans were in place for a range of identified needs, including night time routines, personal care, dementia and living in a safe environment. We did note that on occasions people's weights had not always been recorded at the intervals set out in their care plans. We found that where someone had lost weight, contact had been made with their GP or other healthcare professional to seek advice. We brought the recording issue to the attention of the manager who said she would address this.

Care records were reviewed with the person, their relatives and also professionals. We noted in home improvement records that over the course of one month four families had been involved in reviews. This was an area which had been improved upon and one health care professional confirmed this. Relatives felt included in their family member's care. They commented, "Yes me and my sister helped with it before [person] moved in" and "We were at the beginning."

People had staff who were appointed as their key workers. When we asked a staff member what that meant they told us, "It's about keeping an eye on things like toiletries, keeping their wardrobe tidy and just seeing that their clothes are okay." We asked one person if they knew they had a key worker. They told us they were not aware, but when we asked if anyone tidied their wardrobe or helped with toiletry items they confirmed that staff had supported them with this.

Staff were in the process of completing a person centred one page profile called 'forget me not', of people at the service, which would eventually be placed in each person's room. This was to give a snapshot of the person to staff involved in their care and could be used as a reminiscence aid to the person.

There were mixed views on the activities available to people. People told us, "They ask but I don't go, I just like to watch the TV"; "There is something going on in there [another lounge] today, but I don't want to do it"; "Sometimes we have entertainers, but not a lot [activities]sometimes" and "There is staff who do bits and pieces, but I don't think everyone gets asked." Many of the relatives we spoke with thought that activities could be further improved. Although relatives recognised that improvements had been made with the introduction of a new activity coordinator recently.

We viewed the activity coordinators documentation and found they had documented when one to one conversations had taken place and which activities people had been involved in. This included hand massage, pie and pea supper, involvement with the hens kept at the service, painting and other crafts. We saw pictures on display of people involved with activities with local school children and Easter celebrations for example.

During our inspection the activity coordinator was on holiday. There were limited activities taking place,

which included hand massage for some people on one day. On another day, painting was taking place on the ground floor lounge for three people. We asked the manager why only three people had been involved when an activity room upstairs could accommodate more people. We also asked one person if they were aware that painting was taking place and they told us they were not aware. We completed observations over three days and found suitable stimulation was not always available, particularly in regard to people living with dementia. We spoke with the manager about this and she said that she would ensure that a full programme was in place at all times, including when the activity coordinator is on holiday.

We asked people if they had use of the garden area. Comments included, "We don't get offered to go in the garden"; "Sometimes I sit out, but it's got to be warm"; Not really my cup of tea." People were able to visit the garden, although as previously noted, it was not secure. One staff member told us, "It would be nice if we had a scented area or some more bird feeders."

People were offered choice in everyday matters such as deciding when they wanted to get up and when to go to bed. For example, when we arrived at the service for day one of the inspection, people were starting to wake up on their own fruition, with some coming downstairs to have breakfast when they were ready. Other people were seen asking staff for help before being taken along for breakfast at their request.

Any complaints made had been investigated appropriately by the manager. When we asked people if they knew how to complain, comments included, "If I have any issues I usually tell the staff and they sort it out" Most relatives confirmed they had seen a copy of the complaints procedure and copies were available at the service for people and visitors to access should they need to.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance audits and checks were carried out by senior staff, the manager and the provider. We saw a range which consisted of daily, weekly and monthly checks in a number of areas. These included, checks on medicines, health and safety, catering, dining experiences and infection control. We found that when an issue had been identified, there were actions and comments made regarding when it would be completed and by who. We followed up a number of actions, including maintenance and found they had been completed as stated. The manager completed regular 'walkabouts' and their finding were recorded. The manager also maintained a home improvement plan in which she recorded what work was outstanding and when it was completed.

The provider also had representatives visit the service to complete their own audits and checks, which included for example, an overview of the building, maintenance of records, catering and personnel checks. We found however, that the checks in place had either not uncovered the issues we had found during the inspection or had found the issues, but they still carried on taking place. For example, a provider quality action review completed in January 2017 noted that people's weights had not always been recorded as they should have been or that menus were not displayed appropriately.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection there was a manager in place who had applied to become the registered manager with the Commission. The application was being processed and the manager had been interviewed and a decision was awaited. The manager had years of experience of working with people of all ages who required care and support and had previously worked for a local authority.

We found that not all accidents or incidents had been reported to us in line with the registered provider's legal requirements. We spoke with one relative who told us that a person had become trapped in the lift on one occasion. We confirmed through records that this was the case. We also found, for example, that one person had fallen and fractured a bone and this had not been reported to the Commission. We asked the manager to send the notifications in retrospectively. These issues are being dealt with outside of the inspection process.

People told us they knew and liked the manager. One person told us, "Yes she [manager] is very nice, she was helping out on the floor the other day, she always seems to muck in and help." Another person said, "Oh yes we've met. We had a lady here once that used to wonder during the night and come into our rooms and move things in our drawers, so I told her [manager] about it and she had something done."

People and their relatives told us the manager was approachable. However, the majority of the relatives we spoke with told us they had dealt with either the deputy manager or senior care staff if they had needed to resolve and issue.

On the first day of our inspection the manager announced that she was leaving the service to transfer to another of the providers homes. People accepted the announcement and comments included, "We don't want anyone else we just want you" and "Oh that's a shame, she did not last long." When speaking with staff later, they were disappointed that the manager was leaving to go elsewhere. One said, "It was just starting to settle down, she has worked hard."

We spoke with staff about staff morale and team work as we had been told by one person the night shift and day shift were sometimes at odds with each other. One staff member told us, "I think there is a bit of a divide still with night and day shift. It's a shame because we should all work together." Another staff member told us, "Morale is better but not quite there yet." We saw minutes of staff meetings where staff from day shift had attended and then a separate meeting with night shift had taken place. One staff member told us, "The meetings are much better than they were as everyone gets a chance to attend." The staff were given opportunities to discuss their concerns and raise any issues they needed to.

We saw the results of the 2016 surveys. The report only included the responses from 15 staff members and no responses from people or their relatives. Generally the responses from staff were good, although there were mixed views at the time regarding food and activities at the service. As the management of the home had changed we were not able to establish why no response had been returned from people or their relatives. The manager told us that surveys were in process now and would be collated once the exercise was completed. She understood the importance of gaining people's and their relative's responses as well as staff.

We asked relatives about how the manager and staff communicated with them and if they felt listened to. They told us they had no problem speaking with any of the staff team about issues they needed to and confirmed that they were aware of family meetings taking place. We noted that regular meetings had occurred and the manager had held them at different times to allow families who worked to attend at the evening meeting.

Where safeguarding or other investigations were required, the manager had completed these and taken appropriate actions. The manager told us that she received good support from their regional manager and had the use of their HR (human resource) team to help if they needed. Staff were complimentary about the input the regional manager had with the service. One staff member told us, "She has been here many times and I like her, she seems to really care."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's were not protected from receiving poor care and treatment and were not always kept safe. Safe moving and handling procedures were not always followed. Safe practices in medicines management was not always followed. Regulation 12 (1) (2) (a)(b)(c)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have fully robust quality assurance processes in place as they had not identified the concerns we found during our inspection. Regulation 17 (1) (2) (a)(f)