Avery Homes Grove Park Limited

Grove Park Care Home

Inspection report

100 Grove Lane
Leeds
Yorkshire
LS6 2BG

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 2 March 2016. This was the first inspection of the service.

Grove Park Care Home is situated in the Headingley/Meanwoood area of Leeds. It is a purpose built home with all rooms having en-suite facilities. The home is spread across three suites with a maximum occupancy of 80. At the time of the inspection the service provided nursing care but this was due to cease shortly after our inspection.

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

People who used the service were not protected against the risks associated with the unsafe management of medicines. We found some aspects of medicines management were effective and ensured safety and others were not. There were systems in place to record accidents and incidents and monitor for any patterns or trends. However, we found two serious incidents had occurred regarding medication prescribing and administration and a full investigation had not been completed to show how to prevent any re-occurrence of this.

People told us they enjoyed the food and got the support they needed with meals. However, some improvements were needed to ensure the meal time experience was positive for all people who used the service. Records were not always fully completed to monitor and therefore respond to nutritional and hydration risks for people.

People were not consistently provided with meaningful and stimulating activity. People who used the service and their relatives said there needed to be more to do. Some people who used the service said they were not able to access the 'resident's' meetings to air their views on issues that affected the home.

The provider's system to monitor and assess the quality of service provision was not fully effective. It was not consistently clear that when actions had been identified to improve the service they were always implemented.

People told us they felt safe at the home and there were enough staff to meet their needs. The premises and equipment were well maintained to ensure people's safety. Staff had a good understanding of safeguarding vulnerable adults and knew what to do to keep people safe.

Staff were recruited appropriately in order to ensure they were suitable to work within the home. They were provided with training and support to develop their knowledge and skills. Most staff were trained in the

principles of the MCA and could describe how people were supported to make decisions; and where people did not have the capacity; how decisions were made in their best interests.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity. Care plans contained information relating to people's choices and preferences and staff were able to demonstrate they knew people well.

There were systems in place to ensure complaints and concerns were fully investigated and people who used the service and their relatives said they felt confident to talk to staff about any concerns.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered persons to take in relation to each of these breaches of the regulations at the end 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.

People were not protected against the risks associated with the unsafe management of medicines.

There were systems in place for incident reporting however, we found incidents that had affected the health and welfare of people who used the service had not been thoroughly investigated.

There were sufficient staff who were recruited safely to meet the needs of people who used the service. Staff were trained in recognising and responding to abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Overall, people enjoyed their meals and were supported to have enough to eat and drink. However, the meal time experience was not a positive experience for everyone who used the service and records were not always completed to monitor nutritional and hydration risks.

Legal safeguards were followed to ensure that people's rights were protected. However, some staff's knowledge on MCA and DoLS was lacking and training was required.

People received good support that made sure their healthcare needs were met.

Is the service caring?

Good

The service was caring.

Staff had developed good relationships with the people living at the home and there was a happy, relaxed atmosphere. People told us they were well cared for.

Staff understood how to treat people with dignity and respect and were confident people received good care.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

The range of activities provided were not stimulating or meaningful for all people who used the service.

The care and support people received was based on an assessment of their individual needs.

Systems were in place to respond to any concerns and complaints raised.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

Quality assurance systems were in place but not always consistently applied to ensure improvements in the service.

There were regular meetings which people who used the service so they could comment on the service. However, these were not accessible to all people who used the service to enable them to make their views heard.

Staff were complimentary about the management of the home and said it was a positive place to work.

Grove Park Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 March 2016 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed all the information we held about the home, including statutory notifications and any other information we had received about the service. We contacted the local authority and Healthwatch. We were not made aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted health and social care professionals who were familiar with the service.

At the time of our inspection there were 76 people living at the service. During our visit we spoke with 15 people who used the service, five relatives, ten members of staff which included the registered manager and a supporting manager from another service run by the provider. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at six people's care plans and 12 people's medication records.

The inspection was carried out by two adult social care inspectors, a specialist advisor in medicines, a specialist advisor in governance and dementia and an expert-by-experience who had experience of older people's care services and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed and found although some aspects of medicine management were effective others were not. We found the recording of medicines was difficult to navigate with records located in different places making it hard to see how medicines management was organised. For example on one suite, the stock balance sheets for medication in use could not easily be found by the staff on duty and an investigation had to commence to find them. This means there was a risk that medication administration may not be accurately checked.

Medication administration record (MAR) sheets reflected the times and doses of medicines prescribed. All the MAR sheets we looked at had pictures of the person who used the service as well as their name date of birth and any known allergies. However, we saw there were frequent gaps on the MAR sheets regarding the amount of medicine received in the home which meant
there was no clear audit trail of people's prescribed medicines.

We found two medication errors had occurred. On the day of our inspection one person's MAR sheet was signed at lunch time for a medication administered in the morning. This was brought to the attention of the deputy manager and staff involved by us. It was not clear that this error would have been noticed had we not brought it to their attention. We also saw a person was prescribed a transdermal pain relief patch, to be changed every seventh day. The records showed this had not been done until the eighth day on one occasion. Records showed the person had refused the patch change on the seventh day. However, there was no guidance or protocol in place for what staff should do in the event of refusal. There was no evidence any medical advice had been sought.

There was a lack of person centred evidence in care plans as to how people liked to take their medicines. Care plans did not identify the specific way people liked to take their medicines. As and when necessary (PRN) medication did not have specific instructions or protocols in place for its use. For example, care plans did not state in what circumstances a medication was needed, for example, paracetamol or senna. The home used the Abbey pain scale protocol to assess pain but there did not appear to be any protocols in place as to what level it needed to be before pain relief was given which may be confusing to the person administrating medication and may lead to people not receiving adequate pain relief.

We saw in two of the suites there were liquid medications in use and the date of opening had not been recorded to ensure medication was within its expiry date. There was also a cream and a spray medication without a date of opening. Also one person had paracetamol prescribed which was provided in plastic tubes; one of which had been removed from the original packaging. The only indication of who this medication belonged to was a Christian name of the person that had been written on the tube.

Some people self-administered their medication to maintain their independence. We were told the matron from the GP surgery assessed people's suitability and safety for administering their own medication and we saw a self-medication assessment in a care plan we looked at. People were provided with a locked drawer in their bedroom to store their own medication. However, on the day of our visit, we saw one person who used

the service had left medication unlocked in their unlocked room which posed a risk to other people who used the service. The deputy manager said they would address this with the person who used the service to ensure other people were not at risk from accessing this medication. There were no systems in place to review risk assessments for people who administered their own medication.

We concluded that appropriate arrangements were not in place to ensure people were given their medicines safely. This was a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed medication storage. Controlled drugs (medicines which are more liable to misuse and therefore need close monitoring) were stored securely. Registers were in place to record the handling of controlled drugs and these were in order. Medication rooms were clean and tidy and the medication cabinets were of a high quality. Temperatures were checked daily in the medication rooms and we saw these were within the recommended range for medication storage. Medication fridge temperatures were also checked daily and records showed they were also within the recommended range for safe storage. We saw appropriate procedures in place for separate storage of any medicines awaiting return to the pharmacy.

Staff we spoke with who administered medication told us they had completed medicines training and records we reviewed confirmed this. Staff files contained confirmation an annual competency assessment had been completed. A person who used the service told us the staff gave them their medication when it was due and looked after it all for them so they got it at the right time.

The provider's medication policies were in line with NICE guidance and covered areas such as ordering, storage and disposal, changes to doses of medication, adverse reactions, homely remedies, PRN, errors, medication records, audit and training policies. Staff told us a full medication audit was carried out each month and daily random audits took place. Records we looked at confirmed this. In the PIR, the registered manager stated' 'Medication is audited and errors reported via the significant event report.'

We reviewed the systems in place for reporting of accidents and incidents. We saw two incidents had occurred regarding medicines. One person had been given a prescribed dose of medication which had led to opioid toxicity. There was no evidence that this had been investigated as to why it occurred or what had been done to prevent re-occurrence such as a review of medication with the GP. We also saw another person who used the service had been given ten times the prescribed dose of their medication on several occasions. Medical advice had been sought and we were told the GP had stated the dose given was within therapeutic limits. A plan was put in place for the member of staff who made the error to work under supervision and complete additional medication training. The plan also stated that a route cause analysis should be completed. This was not completed in full to show the possible problems caused by this error. The matter had been reported to the local safeguarding authority; however, the report did not detail clearly that this error had occurred a number of times and was therefore inaccurate. The registered manager agreed to follow this up.

We concluded the above evidence demonstrated a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as incidents that had affected the health and welfare of people who used the service had not been thoroughly investigated to prevent re-occurrence.

People who used the service said they felt safe. Relatives said they felt confident their family member was well cared for and safe. Comments included: "I feel very safe and comfortable"; "It's excellent. We feel confident that [family member's] safe and well cared for; and cared about. [Family member] didn't want to

stay at first, but is perfectly happy now" and "I like it. I've always liked it. I like the place." One person told us another person came in to their room at night if they didn't lock their door.

People told us there were enough staff available to meet their needs. One person said, "They come straight away if I ring my bell, but I don't like to bother them." Another person said, "The staff are all ever so good. I don't think you could do much better. I think there are enough staff on. If there's anything the matter they see to it. They come straight away. They're very good." And a third person said, "The staff pop in to check you're alright. I've never used my call bell. I don't need them at night. If you want someone you just pop your head out, there's usually someone around."

All the staff we spoke with thought there was enough staff to care safely for people living in the home. Rotas we looked at showed staffing levels were provided as planned and worked flexibly to meet the needs of the people who used the service. One health professional we contacted said they sometimes found nursing staff were 'stretched' on the suite where nursing care was provided. The registered manager said the lack of availability of registered nurses had led them to the decision to stop providing nursing care.

Staff told us they had received training to help safeguard people from abuse and training records confirmed this. Staff were able to describe different types of abuse, how to protect people and how recognise signs of abuse. All carers we spoke with had been trained in basic first aid and more senior staff had training in cardio-pulmonary resuscitation. We saw positive interaction throughout our visit and people who used the service appeared happy and comfortable with the staff.

Risks to people who used the service were assessed. We looked at the records for a person at risk from pressure ulcers and the management plans described the care required in an appropriate way. It was not clear from the records, however, that the guidance had been followed in full. Dressings should have been changed every third day. Recent records did not show this was always adhered to or explain why. Staff told us risk assessments helped them to keep people safe. Other risk assessments we looked at included those for mobility, falls, malnutrition, use of bed rails and mental health risks.

There were effective recruitment and selection processes in place. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

We looked around the premises and saw people lived in a comfortable and clean environment. The home was purpose built with wide corridors and doorways. The premises were well maintained, safe and secure. Décor, soft furnishings and furniture were clean, well maintained and appropriate for the needs of people living in the home. Communal areas smelled clean and fresh. Bathrooms and toilets were clean and equipped with liquid hand soap and paper towels. External doors were secured and all windows were fitted with locks and restrictors. A window restrictor prevents a window from opening more than a few inches which means people cannot fit through the aperture and come to harm. Doors to stairwells were secure and could only be accessed using a keypad lock.

Fire alarm points and smoke alarms were fitted throughout the building and fire doors were signed and kept closed. Fire extinguishers were visible on each floor and they had labels showing they had been checked within the previous year. Fire drills had taken place at least every six months; staff said a drill always took place soon after new staff started work. We saw records of fire drills and staff who had taken part had been assessed at that time. If they had not achieved the expected standard, further training had taken place.

The maintenance person described the daily, weekly and monthly checks carried out to ensure a safe environment. We saw records that confirmed this. These included checks of fire alarms and smoke detectors, nurse call system, windows and heating system. Equipment such as hoists, evacuation chairs in upper stairwells, wheelchairs and electric profiling beds had been checked regularly and serviced annually where appropriate to ensure the safety of people living in the home. We saw evidence that independent safety checks had been carried out annually for gas and electrical safety, water hygiene and passenger lifts.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty 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 a number of DoLS applications had been made to the local authority and these were being monitored to ensure they were up to date and in progress. The service had documentation to show DoLS applications had been submitted to the relevant authority where restrictions were in place, and other professionals had been involved in this process, which included a doctor and a best interest assessor.

Mental capacity assessments had been carried out for some people where appropriate and best interest meetings had been held to consider care planning and consent when people were unable to make decisions themselves. However, we found for one person there was a care plan in place to manage the person's variable capacity but no evidence a mental capacity assessment had been carried out to protect their rights.

Overall, staff we spoke with were able to talk in general terms about DoLS, and understood it was a safeguard put in place to protect vulnerable people. Some were not certain who did or did not have a DoLS in place which meant people may not be fully protected. Two staff told us they did not really understand DoLS and why some people had them in place and not others. Some staff knew about the MCA, remembered receiving training about it and described an assessment or test used to determine people's capacity to make their own decisions. They were not all clear about the details of the test. They understood people could make some day to day decisions for themselves, even if they lacked mental capacity for more complex decision making. Training records showed half of the staff still needed training on MCA and DoLS. The registered manager was aware of this and had a plan in place to ensure this was completed by the end of March 2016.

Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions. They all said they would never force anyone to do anything they didn't want to.

People who used the service were, in the main, complimentary about the food and menus in the home.

Some felt that they didn't have much choice, but all said that the food was good quality and well prepared. Comments we received included: "The food is quite good. I get plenty to eat", "The food is good. I enjoy it and I get plenty", "The food's well cooked, but there's not much choice. There's usually a couple of choices and it's very well made, but they don't really ask us what we like." Records, however showed people living in the home had been asked what food and drink they preferred and what, if anything they disliked. This information was recorded in their care files, with dietary requirements and a copy was held by the chefs in the kitchens. A chef told us that when people first came to live at the home, the senior chef always met with them and discussed their food preferences and dietary needs. Staff told us they could telephone the kitchens at any time for food for people. They said there were many choices and egg and chips was a favourite for many people.

Menus changed seasonally and staff told us a survey about food choices would be given to people in the near future. They said the survey would be used to inform new menus. People were given a choice of food each day, selecting from a menu 24 hours in advance. Staff said they read the choices to people and completed a form for each suite every morning. Some people who used the service were living with dementia. Menus were not available in picture formats which can help people living with dementia to better understand the choices available.

Some people required special diets for medical reasons. The chef we spoke with had not received any specific training about preparing special diets. However they showed us information was available in the kitchens about different types of diet for them to refer to. Some people needed different textured diets in order to swallow food safely. The chef understood how this was prepared. When we visited two people needed "fork mashable" diets. Staff told us this was the same food as everyone else was offered, but mashed with a fork to make the consistency safe for people to swallow. .

We observed the lunch time meal in two of the suites. Tables were laid restaurant style with fresh daffodils in vases, table cloths and place settings. People were offered blackcurrant squash or water to drink with their meal. Some people had chosen omelettes and others a cold meal. People said they enjoyed the omelettes. The cold meal was incomplete and potato salad was served at a later time than the main part of the meal and pickles featured on the menu but failed to arrive. No explanation was given for this. People were offered assistance such as help to cut food or provided with aids to make eating and drinking easier for them. Staff were encouraging people to eat and drink and people were offered tea or coffee with their dessert.

In one suite two people who lived in the home came from another dining room and were told they were not 'allowed' in that dining room. This was not respectful. We saw at other times staff were pleasant and respectful but noted there was little interaction from staff during the meal. Towards the end of the meal a member of staff came on duty and greeted everyone, which lifted the atmosphere in the dining room.

Staff explained how a malnutrition risk assessment might lead to referral to a person's GP. They showed us the food and fluid charts that were completed daily for people at risk. However, we saw for one person the fluid balance chart had not been completed efficiently which meant they were not able to effectively monitor fluid balance and hydration. We also saw people's weights were monitored and action taken if needed; for example, soft diet with thickened fluids. However, for one person the care plan said they should be weighed weekly but the records only showed this was being done fortnightly which could lead to a lack of response to nutritional risks.

Records showed arrangements were in place that made sure people's health needs were met. We saw evidence staff had worked with various agencies and made sure people accessed other services when needed. This included; physiotherapist, audiologist, ophthalmologist and GP. In the PIR the registered

manager said, 'When a resident requires medical intervention this is accessed in a timely manner. If a GP or other professional is required then one is contacted immediately. The GP or the Matron routinely visit the home each week to be available to address any queries staff or residents may have.' We contacted a number of health professionals involved with the service and they were complimentary of the service. Comments included; 'From a professional point of view I find [name of person] who is our main liaison carer to be very efficient and always has the patient's best wishes at heart. The home is always happy to act on any suggestions that we make.'

There was a rolling programme of training available. This included; safeguarding adults, food hygiene, moving and handling, infection control, dementia awareness and fire safety. Staff told us they felt they received the training they needed to meet people's needs and fulfil their job role. The training records showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date. Staff said they received an appraisal every six months and supervision every month. They all said they felt well supported by their manager and by colleagues. A person who used the service said, "The staff are nice. Very good. I think they know what they're doing." Supervision records we looked at showed staff received regular one to one or group supervision meetings to discuss their role. However, these were not always monthly as stated in the provider's policy. The registered manager had already identified this and had plans in place to rectify it.

Good

Is the service caring?

Our findings

People who used the service told us they liked the staff and they felt treated kindly and with respect. Relatives all said they felt the staff were very good. Comments included: "The staff are very good, very cheerful. They look after me", "There are some lovely staff. The memory nurse is involved and the OT (occupational therapist) is great", "The staff are all very good. I don't think you could do much better."

Health professionals we contacted all reported the service to be caring. One health professional said, 'The staff are in general very kind and caring. Most staff I feel will ring me when they have concerns so I feel reassured with the care they give.' Another said, 'I find the staff caring and resident centred. The home is well-managed and the residents always appear to be happy with their care.'

Staff told us they really enjoyed working at the home. One said, "I really like the residents, they are lovely and really appreciative." Another said, "I get to help people do stuff I take for granted." They added that some people living in the home had helped them learn new things as well, which showed they valued people who used the service.

Staff were friendly and our observations between staff and people who used the service was at times very positive with the staff speaking very respectfully with people; as well as having friendly banter with them. They appeared to know people's needs well. However, one person said, "The staff are very good on the whole. When I moved in they seemed very aware. Not so sure they're as aware as they were."

On one of the suites, however there was very little interaction at times; staff didn't stop and chat with people, or say hello if they passed them in the corridor. This was a real contrast to another suite where there was more of a 'buzz' of chat between staff and people who used the service. A relative told us, "There are some lovely staff, but I worry [family member] is not cared for in an emotional way; so I worry." A relative also told us their family member would enjoy the chat and conversation in the café on the ground floor of the home. They said their family member was not allowed downstairs. We clarified this with the registered manager who explained the person needed assistance to get there but was certainly able to enjoy the surroundings of the café. They agreed to follow this up with the relative and person who used the service.

People looked well cared for, clean and tidy, which is achieved through good care standards. Several of the women had their nails manicured and people had their hair nicely styled. Staff asked people what they wanted, for instance, at lunch, and responded to their wishes.

Staff were trained in privacy, dignity and respect during their induction. The registered manager said they and the deputy manager worked alongside staff at times to ensure this was always put in to practice and made note of practice during regular walk rounds in the home. In the PIR, the registered manager said, 'Residents are treated with dignity and respect; staff are trained to provide care in a respectful, dignified manner showing compassion when carrying out care. The home promotes dignity champions who influence others to understand the importance of respecting people in a dignified way.' The registered manager said the dignity champions would be expected to demonstrate good practice and challenge any bad practice

with regards to respecting people's dignity at all times.

People who used the service and their relatives were involved in developing and reviewing their care plans. We saw there were plans in place to ensure relatives or people who used the service were asked to sign care plans to demonstrate this involvement. A relative said, "We've been included in discussions about [relative's] care, even though we live away. Whenever there's an issue with health or anything, the doctor comes out and they keep us informed. It's excellent." However, another relative said they did not feel involved enough. They said they had been when the service commenced but not on an on-going basis. In the PIR, the registered manager said, 'Care reviews are part of the planning process and residents and families are involved in this.'

The registered manager told us that no one who lived in the home currently had an advocate. They were however, aware of how to assist people to use this service and spoke of how they had done so in the past. Information on advocacy was available in the home.

Requires Improvement

Is the service responsive?

Our findings

We looked at provision of activity in the service to see if person centred activities were available to people who used the service, if they were provided with stimulation and able to maintain hobbies and interests. In the PIR, the registered manager said, 'If a resident has a particular hobby and this requires staff support then this will be sourced in the most appropriate way. We recognise the importance of social inclusion in the home and that for some this means creative risk management.' However, we found people were not always provided with meaningful and stimulating activity that met their expectations and needs. The registered manager had recognised there was currently an issue with lack of activity provision and was in the process of recruitment of another activity organiser to compliment what they had in place.

A relative told us; "There isn't enough engagement. They only had equipment in the activities room since last week. I don't think they're really good on dementia. They promised the world and it's not quite like that. There's not much to do. I do think they're trying though, but it needs to be more holistic. For instance, they've got some great gardeners, but they could involve the residents more; even just planting up some bulbs in pots or something." A person who used the service said, "I can go down to the garden on a nice day, but I have to ask and they say I have to 'arrange' it. I don't know what they think I'm going to do. I can't go out without someone going with me." This person did not feel they got out enough. Another person said, "I think we really should have meetings where they listen to what we want to do and things like that. I think that's important, but we don't do that. I'm a passionate gardener and I'd love to be involved in the gardening, but we're not allowed." We discussed this with the registered manager who said there were plans for people to be involved in gardening when the weather was improved.

During the day we visited the only organised activity we saw was during a short period in the afternoon when three people enjoyed craft work in a dedicated room on the first floor. The room was well equipped with art and craft supplies, games, jigsaw and media equipment. A staff member told us, "All the staff do things and get an activity going." They explained this might include getting the bingo machine or playing music and encouraging people to exercise or move in time with it. They said there had been a movie on in the morning and said, "I checked that people were actually looking at it."

The records for people living at the home included lists of activities they enjoyed and those they disliked. When they took part in activities it was recorded in their file. We reviewed entries of activity in records for three people over a six week period. One person liked painting, drawing, crosswords, word puzzles, quizzes, exercise classes and classical music. The record showed they had spent time in their bedroom using a computer or watching television or in the coffee shop on most days. They had attended an exercise class twice and enjoyed a quiz on two occasions. They had taken part in a game of scrabble, a creative writing class and an organised reminiscence conversation. Another person liked gardening, painting, drawing, poetry, walking and music. They disliked 'being stuck inside with nothing to do'. It was recorded that the person had been out with family on four occasions and taken part in outdoor activities on three occasions in a six week period. They had joined in an exercise class twice and music and singing activities twice.

Another person had only three recorded activities during the six week period which were 'ground floor for

sherry and company', 'first floor lounge for reminiscence' and 'cinema to watch The Sound of Music'. They liked television and radio, disliked 'being on their own' and spent most of their time in the television lounge on the second floor.

We saw there was a scheduled activity plan in place and each person who used the service was supplied with a copy. On the day of our visit the schedule advertised bingo and table top games as the activity on offer that day. We did not see that any of these scheduled activities took place.

We concluded people were not consistently provided with meaningful and stimulating activity that took their preferences into account and this was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.
Records showed people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the home. The registered manager said there had recently been a re-assessment of the needs of people who used the service in light of the pending withdrawal of nursing care from the home. They said this had resulted in some people needing to find an alternative provider to meet their needs. One relative we spoke with was not happy about the changes and did not feel the consultation about the changes had taken place at a time that was suitable for all to attend.

In the PIR, the registered manager said, 'Care planning is designed to gather information to enable staff to know each resident and engage and assist appropriately. Residents are asked to share life histories to help staff understand them as individuals.' We looked at care plans and found overall they were detailed and individualised. Care plans allowed for many variations and included people's personal preferences as well as their consent to care. Variations were clearly marked on each care plan when appropriate, for example under mobility variations included wheelchair, frame, and stick and gave options for the level of assistance required for each movement. Eating and drinking plans included if the individual preferred tea or coffee and how they took their drink. Choices were respected when planning care, for example the plans noted 'likes to chat with staff', 'prefers to stay in room and read bible', 'dislikes not having his glasses'. We saw 'Life Story' work was completed and included details of people's family, work and interests to help staff get to know people as individuals.

The service had a key-worker system in place. This meant a particular member of staff had been assigned to each person living in the home. Staff told us they always read the care plans for people for whom they were a keyworker and if they were responsible for updating daily records. They said handover at the start of each shift kept them informed about any changes in people's care needs. We asked how they knew they were meeting people's needs. One staff member said, "I ask them" and another said, "Because they tell us." Staff described a process called 'Resident of the Day' which meant everyone living in the home had one day each month when staff spent extra time with them. They were asked about their care and support needs and if necessary changes were made to care plans.

The home had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. In the PIR, the registered manager said, 'Complaints and concerns are received positively with a culture in the home that a complaint or concern is a way of continuous improvement and learning.' We looked at records of complaints and it was clear people had their comments listened to and acted upon. We saw the home had dealt with the issues raised in a prompt and fair way. People who used the service said they would talk to staff or their family members if they had any concerns or complaints. A staff member told us of the learning that had occurred following a safeguarding incident and the need to make sure documentation was completed properly to prevent re-

occurrence of concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager and a team of nursing and staff. We received mixed views on the management of the home from relatives of people who used the service. Comments included; "We've been included in discussions about [family member's] care, even though we live away. It's excellent. Since the change of ownership there's more staff", "It's very professionally run and they follow national guidelines. They keep records and make sure they're up to date. We have found it excellent, first class" and "The management isn't very good or efficient. There are always errors on the billing for instance, and I don't see why they don't seem to be able to sort that out. Communications aren't all they might be. [Name of person] is supposed to have a review every month, but it's only happened once in the last 6 months. The staff are really good; some are excellent, but I don't feel they're well managed."

Health professionals we contacted were complimentary about the management of the home. One health professional said 'All of our patients are up to date on their reviews, and there have been no recent quality issues raised by our nursing team.' Another health professional stated, 'The home is well-managed and the residents always appear to be happy with their care.'

People who used the service were asked for their views about the care and support the service offered. The care provider sent out annual questionnaires for people who used the service. These were collected and analysed to make sure people were satisfied with the service. We looked at the results from the latest survey undertaken in June 2015. The majority of people had rated the home excellent, very good or good overall. We saw some people had rated the food as poor in portion size and taste and an action plan showed what had been done to rectify this; the chef supported the serving of food in a different dining room each day to demonstrate good serving practice. We saw this happened on the day of our visit and no concerns were raised about portion sizes. The registered manager said any suggestions made through the use of surveys would always be followed up to try and ensure the service was continually improving and responding to what people wanted.

'Residents' meetings were held once a month. Agenda items included: Housekeeping, diabetic desserts, salads, activities, language school, meals, fire safety and staffing, laundry labelling, sherry parties. We were told that people from the suite for people living with dementia were not invited to these meetings. We saw a note in a one of the minutes of these meetings to invite relatives of people from this suite to the meetings. We spoke with a person who lived on this suite and as we walked away we heard them say to another person who used the service; "That was nice, wasn't it? I think it's good when they come and talk to us and ask us what we want. They should do it more." A relative of a person who lived with dementia said they did not think people living with dementia were involved in the service as much as they could be. They said, "They seem to be separated from the others, they do not get encouraged to mingle."

In the PIR, the registered said, 'Audits are completed and action points addressed.' We looked at care plan audits completed in December 2015 and February 2016. We saw actions had been noted for people who used the service or their relatives to sign the care plans. At the time of our visit, this had not yet been

completed. We reviewed a Home Review Audit Action Plan from July 2015. It stated that all staff files should have a dated photograph within. This had not yet been completed.

The manager told us the provider had a system of a continuous audit in place which resulted in a quality report submitted monthly. In the PIR, the registered manager said, 'The quality indicator report evidences issues around recruitment and retention, sickness, disciplinary action, staff who have received support and supervision and staff who have received appraisal.' We also saw the audits planned for April 2016 included; legionella, maintenance, health and safety, environment and moving and handling. We found that audits were marked as completed and up to date but actions plans were not always done. We discussed this with the registered manager and they said they did not have to be done. This system of audit would be more effective if the actions taken to address any shortfalls were recorded to show the improvements made.

We were told the regional manager visited the home regularly on behalf of the provider to check standards and the quality of care being provided. The registered manager and staff said they spoke with people who used the service, staff and the management team during these visits. We looked at reports from the visits and saw actions plans were formulated with timescales. For example, that the medication trolley should be locked at all times and keys removed when left unattended. We saw this was adhered to throughout our visit which demonstrated these action plans were effective in ensuring improvements in the service.

Staff told us they were well supported and one added, "If you don't know something there is always someone near to ask." Staff said the registered manager was approachable. One said, "She is tough but fair." All staff spoken with said the registered manager was visible around the home. One staff member said, "We see her every day." Another said they liked that the manager, "Gets straight to the point and explains things well." One staff member said the atmosphere at the home was happy and relaxed. Another said, "It's a good atmosphere, people are happy here."
When asked what was good about the service, one staff said, "We work together to make it as good as we can." (For people living in the home). Other comments we received from staff included; "I'm really happy here. We've got a great team. I'm usually on the second floor, but sometimes go down to the first floor if they're short staffed. I really enjoy the work and love the people."

Staff meetings had taken place regularly and we saw minutes from a staff meeting which had taken place the previous month. Four care staff and three managers had attended. Topics discussed included, sickness and absence, social media use, training attendance, and the keyworker role. The minutes said, 'All present had opportunity to comment.' No comments by the staff were recorded in the minutes. Staff told us they always had an opportunity to discuss items on the agenda and to raise their own issues at staff meetings. One said, "Staff do speak their mind and get a response." Staff told us a change in the way daily progress reports were completed had come about after a discussion during a staff meeting which meant they felt able to contribute to the running of the service.

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 Diagnostic and screening procedures	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people who used the service did not always meet their assessed needs and people were not consistently provided with meaningful and stimulating activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate arrangements were not in place to ensure people were given their medicines safely and incidents that had affected the health and welfare of people who used the service had not been thoroughly investigated to prevent re-occurrence.