Baystone Limited

Cranford Residential Home

Inspection report

15 Cranford Avenue
Exmouth
Devon
EX8 2HS

Tel: 01395263295

Date of inspection visit:
22 May 2017
24 May 2017
06 June 2017

Date of publication:
17 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The service was last inspected on 7, 15 and 18 April 2016 by the Care Quality Commission and was rated as 'Requires Improvement'; there were no breaches of regulations.

The first two days of the inspection were unannounced and took place on 22 and 24 May 2017. We returned on 6 June 2017 to provide feedback to the providers and this was announced to ensure they were available. On this inspection, we judged there were two breaches of regulation relating to recruitment and the management of health and environmental risks. We have made two recommendations relating to supporting people's social interests and achieving good governance.

The previous registered manager had been in post for approximately a year and resigned in April 2017. The providers had made CQC aware of this change and the action they had taken to address these changes. They had arranged for their training consultant to become an acting manager until their newly recruited manager started. The provider advised us that a new manager had been appointed and was due to start in July 2017. 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.

Cranford Residential Home provides accommodation for 26 people, including people living with dementia, a mental health need and a learning disability plus sensory loss. On the first and second days of the inspection there were 20 people living at the home. This had increased to 21 on the third day as a person had returned from hospital.

Since the last inspection, the registered manager had resigned. A new manager had been appointed and their induction planned. In the meantime, the training consultant had recently stepped into the role of acting manager. The provider and the acting manager told us after an induction period, the aim was for the new manager to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 said they felt safe and secure living at the home. They were positive about their relationships with staff, for example in a survey one person said, 'Good atmosphere with caring staff and I can always talk to someone. I do feel you care and that is important.' People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding adults training and understood their responsibility to reports concerns immediately. There were sufficient numbers of suitable staff available at all times to meet people's individual needs.

The providers had a good relationship with staff and the acting manager. Through investment they showed

an on-going commitment to improve the experience of people living and working at the home, including refurbishment. They said they were going to be more pro-active in the running of the home in the future as they had not identified some systems were not in place to ensure the environment was safe and some safety checks were not routinely completed. Improvements were also needed to how staff were recruited and trained. Information within the service user guide needed updating, which included the complaints information.

People using the service also fed back that the current arrangements for activities and social interaction did not meet their needs. We have made a recommendation about supporting people to meet their individual interests. Communication about changes within the home still needed to be developed to include people living at the home, although this had improved for the staff group.

Staff were positive about the team work at the home and the improvements being made to support them carry out their job. For example, steps were being taken by the acting manager to address overdue supervisions, improve inductions and provide a range of training. Work had taken place to improve staff understanding about the importance of recording. Areas for further improvement were identified during the inspection but this was addressed and records had improved by the third day of inspection.

Staff respected people's choices and valued people as individuals knowing when to change their approach based on their knowledge of the person. Staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were systems to monitor the quality of the service, including responding to suggestions for improvements. Medicines were well managed.

People were offered a choice of meals. They were supported with their health needs and had access to health professionals, when necessary. They told us staff were caring and respected their privacy and dignity.

We judged there were three breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.
Recruitment practices did not consistently ensure staff recruited were suitable to work with vulnerable people.
There were not effective and consistent systems to check some of the safety equipment.
The recording of how some risks to people's health were managed was inconsistent; this had improved by the third day of our inspection.
There were sufficient numbers of staff within the service to keep people safe and meet their needs.
Medicines were managed well.
Staff knew their responsibilities to safeguard vulnerable people and to report abuse.

Is the service effective?

Good

The service was effective

Action was being taken to address shortfalls in staff supervision and inductions. A range of training had been organised to equip staff to support people appropriately, although this did not yet include training to care for the range of people living at the home.
The environment was well-maintained with on-going improvements.
Staff understood the principles of the Mental Capacity Act which was shown in their approach and practice. People had access to health professionals.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was good.
People were supported by staff who were kind and caring.
People were involved in decisions linked to their care and daily life.
Staff knew people well and there was a friendly atmosphere.

Is the service responsive?

Requires Improvement

Most aspects of the service were responsive.
However, people living at the home identified how arrangements to meet their social needs needed to be improved.
Care plans were detailed and person centred and showed respect for people's individual care needs and wishes.
People were confident their complaints would be listened and acted upon, although because of staff changes some people were unsure who they speak with about concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The providers regularly visited the home and were committed to investing and improving the service. However, they had not identified some shortfalls in the running of the home, which included some safety checks, recruitment procedures and how staff were supported.

People living at the service had not been kept updated about the management changes within the home. Some information about the service was not up to date. However, people living and working at the home told us there was a positive and friendly atmosphere.

The providers had kept CQC up to date with the management changes at the home and been proactive in ensuring an acting manager was in place until a new permanent manager took up their position.

Cranford Residential Home

Detailed findings

Background to this inspection

The service was last inspected on 7, 15 and 18 April 2016 by the Care Quality Commission and was rated as 'Requires Improvement'; there were no breaches of regulations.

The first two days of the inspection were unannounced and took place on 22 and 24 May 2017. We returned on 6 June 2017 to provide feedback to the providers and this was announced to ensure they were available. On this inspection, we judged there were two breaches of regulation relating to recruitment and the management of health and environmental risks. We have made two recommendations relating to supporting people's social interests and achieving good governance.

The previous registered manager had been in post for approximately a year and resigned in April 2017. The providers had made CQC aware of this change and the action they had taken to address these changes. They had arranged for their training consultant to become an acting manager until their newly recruited manager started. The provider advised us that a new manager had been appointed and was due to start in July 2017. 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.

Cranford Residential Home provides accommodation for 26 people, including people living with dementia, a mental health need and a learning disability plus sensory loss. On the first and second days of the inspection there were 20 people living at the home. This had increased to 21 on the third day as a person had returned from hospital.

Since the last inspection, the registered manager had resigned. A new manager had been appointed and their induction planned. In the meantime, the training consultant had recently stepped into the role of acting manager. The provider and the acting manager told us after an induction period, the aim was for the new manager to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 said they felt safe and secure living at the home. They were positive about their relationships with staff, for example in a survey one person said, 'Good atmosphere with caring staff and I can always talk to someone. I do feel you care and that is important.' People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding adults training and understood their responsibility to reports concerns immediately. There were sufficient numbers of suitable staff available at all times to meet people's individual needs.

The providers had a good relationship with staff and the acting manager. Through investment they showed an on-going commitment to improve the experience of people living and working at the home, including refurbishment. They said they were going to be more pro-active in the running of the home in the future as they had not identified some systems were not in place to ensure the environment was safe and some safety checks were not routinely completed. Improvements were also needed to how staff were recruited and trained. Information within the service user guide needed updating, which included the complaints information.

People using the service also fed back that the current arrangements for activities and social interaction did not meet their needs. We have made a recommendation about supporting people to meet their individual interests. Communication about changes within the home still needed to be developed to include people living at the home, although this had improved for the staff group.

Staff were positive about the team work at the home and the improvements being made to support them carry out their job. For example, steps were being taken by the acting manager to address overdue supervisions, improve inductions and provide a range of training. Work had taken place to improve staff understanding about the importance of recording. Areas for further improvement were identified during the inspection but this was addressed and records had improved by the third day of inspection.

Staff respected people's choices and valued people as individuals knowing when to change their approach based on their knowledge of the person. Staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were systems to monitor the quality of the service, including responding to suggestions for improvements. Medicines were well managed.

People were offered a choice of meals. They were supported with their health needs and had access to health professionals, when necessary. They told us staff were caring and respected their privacy and dignity.

We judged there were three breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

Requires Improvement

Is the service safe?

Our findings

Improvement was needed to some aspects of the recruitment process. In the staff files for two staff members only one reference was recorded as received for each of them. Alternative references had not been sought and there was no record of follow up phone calls to show that action had been taken to address this deficit. One care staff member's file did not record an explanation for gaps in their employment history. Lack of full employment history could mean staff who were unsuitable for this role, could be employed without this information being known. This lack of information was rectified during the inspection.

The regulations have a clear schedule of exactly what needs to be obtained to ensure new staff are fit and appropriate to work with vulnerable people. This includes obtaining two references and a full employment history.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers assured us they 'spot checked' how staff were recruited but had not kept records of these checks. They said new staff would now be recruited in line with the regulation. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This information was in place before staff started working at the home.

People's care assessments included identified risks, as well as information about how to reduce risks. For example, identifying risks of developing pressure sores from reduced mobility and skin breakdown and the equipment and type of care to use to address the concern. There was a system of 'comfort rounds' in place for some people who were particularly frail. These were to check on the well-being of people cared for in their rooms. Some people also had charts in place to record when they were turned to help prevent skin damage. People used pressure relieving equipment as stated in their care plans.

Improvements were needed to some aspects managing risks to people's health and well-being. We checked the recording of when people were turned to help reduce pressure damage. According to records this was not routinely taking place at the assessed time. For example, a person was assessed to be moved every four hours but charts showed on occasions they were not moved for five hours or seven hours. There was no record staff had raised this delay as a concern or that the records had been audited to check staff were following the instructions of four hourly turns. A staff member said this care had taken place as people's skin had not been damaged. The acting manager said staff would be reminded to complete the records.

By the third day of our inspection, the completion of records for five days linked to turning people in bed had improved. It was unclear from some of the forms how often the person should be moved as this section had not been completed, although this information was in the care plan and in handover information. However, this information was particularly relevant as agency staff worked at the home and therefore needed clear instructions as they did not work consistently at the home.

Improvement was needed to ensure there was a consistent approach to monitor people's weight and respond to risks. For example, we identified that a person had lost weight but action had not been taken to monitor if this was a continuing risk to their health or seek medical advice. Staff said they had queried the accuracy of how the scales were being used but had not re-checked the person's weight until four weeks later. A food intake chart had been put in place for seven days but had been stopped after several days with no recorded explanation. Records showed the person's weight had now increased.

However, for another person action was taken promptly when weight loss had been identified. Health professionals were involved to assess them and their advice followed, although their care plan had not been updated to reflect this action. During the inspection and following our feedback, action was taken to instigate a system to record weights on a regular basis. Staff said this would help them to identify who was at risk of weight loss and how often their weight should be monitored. A visitor told us they were very happy with the standard of care. They said their relative had "thrived" since moving to the home and had put on weight.

Improvement was needed to ensure there were effective and consistent systems to check some of the safety equipment. The purpose was to keep the environment safe for the people living and working there. For example, weekly checks on fire extinguishers had not taken place for a period of seven weeks. An audit had been started in April 2017 on fire call points but this was incomplete and there were no other records. Records for checking emergency lighting logged faults but not what action had been taken; the provider said they would ensure this was addressed. There was not a system to check window restrictors were working effectively. During the inspection, these were checked by the provider who assured us none were faulty and a checklist was put in place by staff to introduce a monthly system.

The provider told us a system had been fitted to hot water taps to ensure the temperature was regulated and within Health and Safety Executive (HSE) guidelines. A check of water temperatures had been completed by a staff member in April 2017 but there was not a record of the action taken to address several water temperatures that had the potential to put people at risk of scalding. There were no records of previous checks in 2017. The provider checked water temperatures during the inspection and confirmed they were within HSE recommended levels; we were told a regular check would become part of the home's routine safety checks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the external contract arrangements for safety checks and saw these were all up to date. For example, regular checks had taken place for servicing equipment such as gas appliances, portable electric appliances, moving and handling equipment and the lift. Each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire.

There were sufficient numbers of staff on duty to keep people safe and meet their care needs. Staff rotas reflected the staff on duty. There was a senior care worker on each day and night shift. In the morning they were supported by five care staff. In the afternoon, they were supported by three staff, which increased to four care staff on some days. There were two waking care staff at night. Care staff were supported by kitchen staff, housekeeping staff and office staff. The acting manager explained how they had recently introduced a new tool to assess people's dependency levels to help ensure staffing levels met people's needs.

Due to staff vacancies, some staff, such as senior care workers had been working over their contracted hours. They told us they were committed to ensuring people living at the home were safe and therefore

picked up extra shifts. This included, night shifts when staff resigned unexpectedly or were off sick. We discussed this issue with the providers and the acting manager as we needed reassurance staffing vacancies were being addressed. On the third day of the inspection, a new full-time staff member had been recruited to be a senior care worker, subject to references, and another person was being interviewed. The providers told us they would not admit new people to the home until new staff had been recruited. The providers recognised the importance of maintaining staffing levels on shifts and gave staff permission to arrange agency staff cover when needed, which staff confirmed. They recognised as more people moved to the home, they would need to employ more staff and increase the numbers of staff on shift.

Staff said they worked well as a team. Some staff were still learning how to use a 'walkie talkie' system appropriately and guidelines had been produced to help make the system effective. There was a call bell system, which people living at the home used to call for help, with screens at strategic points around the home to alert staff to the person's room number. Several people told us the sound of the call bell system could be intrusive especially at busy times of the day, such as the evening, when people were going to bed. For example, one person said "...it gets on your nerves after a while." We monitored the response times to the call bell systems in the evening; staff were busy but responded in a timely manner. People showed us their call bells in their rooms which were all in reach; they said staff came when they called for help. We spent time at the home in the early evening on the second day; we fed back to the provider that for a period of time people in the lounge were not supervised by staff. One person was at risk of falls; on several occasions they tried to stand and became entangled in their call bell so we had to intervene to keep them safe. Following our feedback, changes were quickly made to the timing of staff breaks and the location of staff handovers to ensure communal areas were supervised.

Staff received safeguarding adults training, which helped them to understand how to protect people from potential abuse and avoidable harm. Staff knew when to report various types of abuse and where to find contact details for external agencies. The providers had worked closely with the safeguarding team, commissioners and community nurses to address a concern relating to catheter care for one person. Following an internal investigation, they were open regarding the lessons that had been learnt; staff had received catheter care updates and had their work observed to ensure they put their learning into practice.

Medicines were safely managed, apart from the monitoring of the temperature within the medicines' fridge, which had not been recorded for nine weeks. Staff said this was an oversight and would be addressed. People received their medicines safely and they said they were given on time and never missed. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines administered were documented correctly in people's Medicine Administration Records (MAR).

We observed a staff member administer medicines during the inspection; they ensured medicines were kept secure. They monitored people's pain levels and this information was handed over to staff on the next shift. They followed up discrepancies with the pharmacy to ensure they had the correct medicines in stock and kept a record of their requests. We checked medicine stock against what the medicine records evidenced; these were correct. Some people were prescribed medicines which required additional measures to keep them safe; 20 out of 21 entries were double signed, which showed correct practice. Medicine practice was audited and the acting manager explained the steps taken to address errors.

The environment was kept clean and free from unpleasant odours. People said they were happy with the standard of cleanliness in their rooms. Protective clothing and gloves were available in all areas of the building for staff to use; staff explained how they maintained good infection control standards. A new housekeeper had introduced new cleaning systems to the home, including a regular rota of deep cleaning

for bedrooms. They identified equipment in the laundry needed replacing to an industrial standard, which the providers had provided. This enabled staff to work more efficiently and maintain good infection control standards.

Good

Is the service effective?

Our findings

Improvements were needed to some aspects of induction and formal supervision of staff. However, this area for improvement had recently been identified by the acting manager and was being addressed. The acting manager was an external training consultant who was also employed by the providers to deliver training at the home. In April 2017, their remit had increased to also act as support for staff during a management change within the home. In this additional temporary role, they had identified staff members who had not previously received a thorough induction and had not received regular supervision, particularly when they were new in post. For example, a staff member who had not worked in care before had no records of supervision to show how their practice was being monitored or what training had been identified to develop their skills.

We shared some concerns with the providers about a staff member's approach towards some people which did not demonstrate person centred practice. We highlighted the gaps in their induction; the acting manager had recognised this care worker needed additional monitoring. They explained how they would address our concerns and the lack of supervision for this staff member. We also highlighted to the providers how in the last year people with different care needs had moved to the home and as yet the training provided did not reflect these changes. For example staff had not been provided with training in understanding and supporting with mental health needs or a learning disability, although they could explain how they supported them and people's care plans gave them guidance. The providers said they would discuss this with the acting manager to see how this could be addressed.

The acting manager had begun to address shortfalls in the staff members' inductions by supporting staff to retrospectively complete the Care Certificate. This is a nationally recognised set of standards that health and social care workers are expected to adhere to in their work experience. They had also undertaken in depth supervision with most care workers, which included observations of their practice. Records were thorough and demonstrated the involvement of staff in their discussions around training and development. Some staff said they had not previously received additional support when changing roles with increased responsibilities, which records confirmed. Staff told us they now felt supported by each other and by the acting manager; they gave examples of when they had contacted the acting manager for advice regarding caring for people living at the home. They welcomed the start of the new manager at the home to oversee the changes taking place.

Training records showed that a range of staff training had been completed in a short space of time to ensure staff had the right skills. Staff had signed up for future training. Staff were positive about the accessibility of training and the recognition by the providers that it was important. For example, staff were paid to attend. The acting manager explained how they ensured staff who could not attend training due to sickness were supported on a one to one basis to complete workbooks on the topic they had missed.

People said there had been a number of changes of staff but they did not raise concerns about the practice of staff. For example, a person told us they felt safe when staff used equipment to move them. Staff explained to people how they would assist them to move. They did not rush them and assisted at the

person's pace.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) following training and how these applied to their practice. Half of the care staff had completed training and the remainder had training planned for June 2017.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Staff told us no applications had been made and explained their reasons why. They were monitoring the behaviour of one person who had newly moved to the service following recent feedback from the person's relative about a potential risk of them leaving the building and being unsafe. On the third day of our inspection, staff told us they had assessed the person further and they had concluded an application was not currently needed.

Staff checked with people how they wanted to be supported and care plans showed people had signed to agree to their care being assessed and a care record being completed. However, some people knew they had a care plan but had not felt involved in its creation or content. The acting manager said this would be addressed at the next care plan review to ensure people were happy with the wording and information. Some people had chosen to have support from friends or relatives to manage and assist with financial and/or care and welfare decisions when they no longer had the mental capacity. Reference was made to these arrangements in people's care plans but staff had not ensured a copy was on file to ensure people's rights were protected. Staff began to address this discrepancy during the inspection.

People told us they could access health professionals and we saw people being accompanied to health appointments. Staff ensured people had access to information about their health appointments, such as outpatient visits to the hospital. Staff ensured people were included in the plans to attend appointments. People's records showed health professionals were contacted if their health deteriorated and staff followed up with GP surgeries if there were delays in providing new prescriptions or visits. People told us they had access to an optician and dentist. Records showed staff recognised changes to people's health and requested support from the Speech and Language Therapy team regarding food preparation and how to provide drinks in an appropriate manner.

Staff said appropriate information was shared with them on each shift. We participated in a handover; staff made their own notes to help them on their shift. Important information was shared so staff could monitor changes to people's health and well-being. Care plans provided guidance for staff to assist in the way they communicated with people they cared for. People confirmed staff ensured their glasses and hearing aids were made available.

Since the last inspection, the providers had made significant investments to the environment of the home. This included refurbishing bedrooms with new furniture and carpets. En-suite facilities were being added to some rooms in recognition of providing more privacy. Staff said the previous manager had made a number of positive changes to the layout of communal areas. For example, improving the dining room area to make it a more attractive place to spend time. Staff said the changes to the room had made it more popular and more people were using it for their meals. However, staff said lack of space meant seating was limited. We saw one person using equipment to move found the dining room difficult to access because of the width of the doorway and the lack of space to manoeuvre. It was positive that the room had become more popular

but staff recognised changes were needed to ensure people who wanted to eat in a communal environment could do so.

People were positive about food choices, variety, portion sizes and said their dietary preferences were met. People described the food as "very good", "all right", "OK" and "I enjoy the food." A visitor said staff always remembered their relative's food dislikes and ensured there were always alternative meals available; people living at home also said alternatives were offered. One person said their food was prepared in a specialist manner to help reduce the risk of them choking. A residents' meeting took place in May 2017 attended by 12 people living at the home; people were asked for their views on the menus. People's responses were positive about the quality of the food and their suggestions were noted to be considered as part of the menu review.

People were offered drinks and snacks regularly throughout the day. Records were kept to monitor people's fluid intake; we checked people's records. There were regular entries and their intake usually met national guidelines. A new system had been introduced following learning from a safeguarding incident relating to catheter care. Senior staff now audited the fluid records to monitor whether the goal for the person's fluid intake had been reached, although this was still work in progress as it was not happening routinely.

Good

Is the service caring?

Our findings

We met with people in their rooms and in communal areas. They commented positively on the way staff treated them, particularly one staff member who they said went out of their way to make time to spend with them. For example, to complete a crossword or to sit and have a chat. A relative also commented on the skills of this individual staff member saying their skills were "truly amazing." However, they added all staff were friendly and welcoming. People said they would recommend the home to other people if they were considering moving into a residential care home. They were positive about their relationships with staff, for example in a survey one person said, 'Good atmosphere with caring staff and I can always talk to someone. I do feel you care and that is important.' We saw that some staff were particularly skilled and gentle in their approach. For example, one person looked confused and disorientated when they woke up. A care worker took time to give them eye contact and reassurance. The person smiled and later walked to their room with the staff member saying "You're my darling."

The staff group had changed significantly since our last inspection. For example, 16 care staff out of a team of 19 had been in post less than nine months. People said new staff were usually introduced to them and wore name badges to help identify them. Staff who had recently joined the staff team said how much they liked the welcoming and friendly atmosphere. They all said they intended to stay and recognised there had been a number of staff changes for people living at the home to get used to.

We asked people if they were treated with dignity and respect by staff and they confirmed they were. They gave examples of how staff supported them with having a bath or shower. This was managed well by staff so they did not feel embarrassed. Some people said they generally had the same staff member support them with this type of care; other people said it varied but said they did not mind this. Most people were happy with the frequency and when this support was provided. People looked well cared for. One person told us "the staff are very attentive." People told us they had a good service from the laundry with their clothes well cared for and items rarely mislaid. One person commented that the laundry service was "very good and very quick."

Each person was encouraged to personalise their room with things that were meaningful to them. For example, with photographs and items of furniture. People said this was important to them, especially those people who told us they chose to mainly stay in their room. People said their bed was comfortable and they had the furniture they needed in their room, such as a chair for a visitor or a lockable storage space. People said staff checked with them before visitors were shown into their room, which they appreciated as this protected their privacy and ensured they gave their consent.

Staff talked with us about individuals living at the home in a compassionate and caring way. They demonstrated a good knowledge of people's needs, and their likes and dislikes. Care plans contained information about people's individual choices and preferences. This enabled staff to have a good knowledge of the people and events special to them.

Staff were considerate and caring in their manner with people and knew people's needs well. They were

friendly and supportive when assisting people. A person commented in their survey "all staff cheerful and caring to everyone." They treated them with dignity and respect when helping with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, and told us how they tried to maintain people's dignity with personal care. They gained consent before providing care.

Requires Improvement

Is the service responsive?

Our findings

Improvement was needed to ensure there were regular activities and support to maintain people's individual interests. The last time we inspected in April 2016, people fed back there had previously been a good activities programme but due to staff leaving this was no longer the case, which the providers said they would address. On this inspection, we found people were still commenting that social activities could be improved.

We saw a regular feature of each week was chair exercises, which we saw some people participating in. Some people later told us they enjoyed the session. People also had access to hand massages and a hairdresser. However, several people commented they would like more activities in the home on a regular basis. Records showed there were few other activities that regularly took place. Other people said they would like to be told about activities even if they usually stayed in their room. A poster in the hall displayed an activities programme, which was not current.

People who preferred to stay in their room said they would like staff to have more time to spend chatting with them or to complete a crossword with them. Their care plans identified social contact was important to their well-being. Several people said they felt isolated as they chose to stay in their room but felt there was not enough social contact; one said "I don't feel part of a family."

People's records showed few entries for activities with some only having one or two entries per month. The acting manager said this might be partly due to staff not completing records, which they said would be addressed when a new recording system was introduced to the home. Minutes from a residents' meeting on 25 May 2017 showed the acting manager raised activities as a topic for discussion and people's ideas were collated. The provider attended the meeting and encouraged people to share their ideas to see if they could be implemented in the future.

Some people told us they would like to access the community, such as going into town or shopping. They said this used to happen on a regular basis but had not happened for several months, which records confirmed. We saw from people's care plans that some people had stated contact with the local community was important to their emotional well-being. During the inspection, two of these people were supported to arrange an evening out together. A relative commented in their feedback to a survey from the service that regular weekly outings from the home are the utmost important to (X) well-being.' The providers said the staff member who had provided this type of support was not currently working at the home. Staff were encouraged to instigate activity sessions, such as games in the lounge but conversations with people living at the home and the recording of activities did not confirm this met people's needs and interests.

We recommend that that the service seek advice and guidance from a reputable source about supporting people to meet their individual interests and create a system to review if the new approach is successful.

The acting manager had been in this role since April 2017 and had arranged a fundraising event for a charity with live music in June 2017 and a garden party. They had also suggested a trip to see the local town band

play, which a number of people expressed an interest in attending. People told us that even if they chose not participate in events in the home's garden; they enjoyed watching from their bedroom windows, for example a firework display. People could access the garden and told us they took pleasure in using it. People said they enjoyed reading newspapers which they had delivered to them; one person said they enjoyed using the library service that visited the home. They commented on the kindness of staff who brought in books for them to read.

Before people moved to the home an assessment of their needs was completed to ensure the service could meet their needs. People confirmed this happened and staff told us how they visited people in their own homes or in hospital to discuss their care and social needs. This information was then used to generate care plans to assist staff to provide individual care and support.

Care records detailed people's personal and healthcare needs and were updated and reviewed regularly. Information was set our clearly. This meant staff knew how to respond to individual circumstances or situations, which was confirmed by our discussions with them and observations of their practice. Care files included people's preferred routines and what people's current assessed needs. This covered personal care, general physical health, mobility, risks and communication.

People received personalised care and support specific to their needs and preferences. People said the daily routines were flexible. For example, they could choose when they got up and when they went to bed. They said staff respected their wishes regarding where they spent their time.

Staff told us they were given the right level of information to meet people's care needs, for example how to respond to their anxieties or obsessive behaviour. Information was personalised; this meant that when staff were caring for people they knew their choices, likes and dislikes and provided appropriate care and support. The acting manager said reviews were being set up with each person to ensure they were happy with the content before it was transferred to a new electronic care system.

Complaint information was displayed in the entrance hall. People and relatives said they had no complaints about the home but not everyone was confident about how they would make a complaint given the staff and management changes within the home. We fed this back to the providers. At a residents' meeting which took place before the last day of our inspection, the acting manager advised people who they could speak with until the new manager started work at the home. We were told minutes of the meeting would be shared with everyone at the home. The provider had a written complaints policy and procedure; information about how to complain was on display in the home. However, the service user guide's complaint information was not up to date as it referred to a manager who in left in early 2016.

The complaints log showed formal complaints were addressed by the providers and where necessary lessons were learnt. Complaints were used as an opportunity to resolve issues and make wider improvements. For example, observing staff practice to ensure staff had the correct skills regarding catheter care.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was not a registered manager in post. They had left the service in April 2017. The deputy manager post was also vacant. The providers had made CQC aware of these changes and the action they had taken to address these changes. They had arranged for their training consultant to become an acting manager until their newly recruited manager started. The acting manager was initially spending two days a week at the home. The providers told us they wanted the new manager to be involved in the recruitment of the deputy manager. In the meantime, a senior care worker had taken on extra responsibilities; they told us the acting manager was approachable and supportive. The acting manager told us they were working with the providers to keep the service safe during the management transition. They showed us the induction schedule planned for the new manager.

At our last inspection, people living at the home told us they had not been kept informed about how staff changes were being managed. We heard similar comments from some people living at the home about the current management changes. For example one person was quite upset as they had not been told the registered manager had left. We raised this with the providers and they confirmed they had not formally notified people living at the home. After our second day of inspection, people were informed that a new manager had been appointed at a residents' meeting. Two relatives said they had heard from staff that a new manager was joining the home but had not been told formally. In contrast to our last inspection, this time staff said they had been informed via a letter that a new manager had been recruited and some staff members had met the new manager.

The providers regularly visited the home but did not always become directly involved in decisions relating to the running of the home. For example, changes to the range of people living at the home and not reviewing the statement of purpose to ensure it was up to date. Training had not been reviewed to ensure staff had the skills and knowledge to meet the needs of people with a learning disability or people with mental health needs or a people living with a head injury. The providers said they spot checked records linked to the running of the home and visited the home regularly. They had not identified that improvement was needed in the recruitment process, managing health and environmental risks, the regularity of staff supervisions, the range of activities and updating documentation relating to the home. At the time of the inspection, the home's website was being updated and was not available; a visitor said this would have been useful when they were looking for a home for their relative.

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

The providers said they had not been involved in the completion of the Provider Information Return, which contained information they had not approved. During the inspection, we were supplied with an updated version which they had completed with the acting manager. This outlined where standards had been met and areas for improvement and how they would be addressed.

The providers said they would be more pro-active in future decisions regarding how the home was run. They

had decided to invest in an electronic care record system to improve the standard of recording and staff had already been identified to help roll out the training programme once it was in place. A member from Devon Quality Assurance and Improvement team visited the home during our inspection. They were satisfied with the comprehensive approach taken by the acting manager to address a safeguarding concern to ensure staff competencies had been assessed and lessons learnt to prevent a similar incident happening again.

Staff told us the providers visited the home most days and were helpful and supportive. They praised the good working atmosphere of the home and the providers' willingness to listen to ideas. They were described as "good people" and "the kindest providers." Work was being undertaken by the acting manager to address shortfalls in the way staff were supported. For example, supervisions had not happened regularly for some newer staff and some staff who had not worked in care before had not benefited from a comprehensive induction. Staff said they felt a new confidence in the way they worked and staff member said they were now "a brilliant team" and the staff group was "really friendly." When we spoke with staff they complimented other staff members for their skills and support; this showed a positive working culture where staff valued each other and recognised the importance of team work to benefit the people living at the home. They recognised how less experienced staff needed reassurance and support; they commented how one staff member was now "blooming" as their confidence grew.

In July 2016, the acting manager had assisted the service in their previous role as training consultant to complete a quality assurance check on the service. They had worked with the previous registered manager to draw up a self-assessment document for areas of improvement. We were provided with a copy but there was not a log of when actions had been completed. The acting manager was in the process of reviewing what work had been completed and provided us with a 6 monthly checklist completed in May 2017 which was comprehensive and clearly showed the action taken to address issues and timescales. For example, they had undertaken an audit of eight care plans in May 2017 and taken action where further information was needed. The appointment of the acting manager showed the providers recognised work the importance of a manager's role to reassure staff and people living at the home regarding the running of the home.

Records showed residents' meeting did not happen regularly, which people living at the home confirmed. Some said they would attend if one took place, which was shown by 12 people's attendance at a residents' meeting on 25 May 2017. Others said they would rather be consulted but not attend a meeting. People had the opportunity to comment on the service through surveys. These had been collated in December 2016 and June 2017. People who used the service were more positive in the survey for June 2017 and had identified fewer areas for improvement. For example, there were no comments about improving staff approach, which was a feature in the survey for December 2016. Instead the focus for improvement was to increase activities and support to maintain their well-being. A person told us they had chosen the home because there were "happy people" in it. This comment reflected our conversations with staff who were positive about the working atmosphere of the home. When asked about their job, they said "I absolutely love it" and displayed a confidence in how they cared and supported people. A staff member said in terms of equipment and the working environment, "I'm really well looked after."

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 There were not effective and consistent systems to check some of the safety equipment. The recording of how some risks to people's health were managed was inconsistent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Improvements were needed in the running of the home, including how activities were provided, some safety checks, recruitment procedures and how staff were supported. People living at the service had not been kept updated about the management changes within the home. Some information about the service was not up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices did not consistently ensure staff recruited were suitable to work with vulnerable people.