Woodleigh Christian Care Home Limited

Woodleigh Christian Care Home

Inspection report

Norfolk Drive
Mansfield
Nottingham
NG19 7AG

Tel: 01623420459
Website: www.woodleighcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 31 October 2017 and the inspection was unannounced. The service is registered to provide accommodation with personal care for up to 44 older people with varying support needs, including nursing needs. On the day of our inspection there were 29 people living at the service.

Woodleigh Christian Care Home is required to have a registered manager. 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 home is run. At the time of our inspection a registered manager was in place but not available on the day of our inspection. The provider's operations manager had day to day responsibility for the service and was present during the inspection.

People could not be assured their prescribed medicines were managed appropriately. Some concerns were identified with the deployment of staff that meant staff were not always available in communal areas placing some people at risk. Whilst action was taken on the day to address this, continued review and monitoring is required to ensure people's safety is not compromised. Safe staff recruitment procedures were in place and being used.

People's needs had been assessed and any associated risks were planned for. However, staff did not always follow information provided impacting on some people's safety. Accidents and incidents were recorded and reported by staff. These were analysed to ensure appropriate action had been taken to protect people, and to consider if there were any themes or patterns that required further action. Contingency plans were in place to support staff to provide a safe service in the event of an untoward incident affecting the service.

Staff were trained in adult safeguarding procedures and knew what to do if they considered someone was at risk of harm or if they needed to report concerns.

People were not always supported effectively by staff. Some staff required further training and support to improve their practice. New staff received an induction and all staff had ongoing training. Staff had not received the required frequency of supervision meetings to discuss and review their development needs as stated in the provider's supervision policy and procedure.

Policies and procedures were in place to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Whilst people's mental capacity had been assessed where required, best interest decisions had not been recorded to show who and how decisions had been made and that less restrictive options had been considered. This is a requirement of this legislation.

People received sufficient to eat and drink and their nutritional needs had been assessed and planned for. People were appropriately supported with their eating and drinking needs if required, choices were offered and respected, and independence encouraged as fully as possible.

People's health needs had been assessed and planed for. However, further improvements were required in some areas of clinical care.

Staff on the whole were kind and caring; experienced staff knew people well and supported people in a dignified and respectful way. Staff acknowledged and promoted people's privacy. People felt staff were understanding of their needs and that they had developed positive relationships with them. Information about an independent advocacy service was available for people should this support have been required.

People and or their relative where appropriate, were involved in the assessment and review of their needs. Care plans informed staff how to support people and were on the whole personalised to people's needs, routines and preferences. Activity staff provided a range of one to one and social activities and opportunities. People and staff knew how to raise concerns and these were dealt with appropriately.

People who used the service and relatives or representatives, were given opportunities to share their experience of the service. Quality assurance systems were in place to regularly review the quality and safety of the service provided however, these were found to require improvement.

During this inspection we found concerns relating to the safe care and treatment of people and this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

The service was not consistently safe.

People's prescribed medicines were not managed and monitored safely or effectively.

The deployment of staff required ongoing monitoring to ensure people were supervised to protect their safety. Safe staff recruitment procedures were in place and followed.

People's individual risks had been assessed and planned for but staff were not always adhering to these plans.

Staff had received appropriate safeguarding training and were aware of how to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received an induction, training and ongoing support. Some new staff required additional training and support to enable them to provide effective care.

People's rights were not fully protected by the use of the Mental Capacity Act 2005. Best interest decisions were not recorded as required as part of this legislation.

People's hydration and nutritional needs were met and meal choices provided.

People had their healthcare needs assessed and planned for. Further improvements were required in relation to diabetes care.

Is the service caring?

Good

The service was caring.

People were cared for by staff who on the whole showed kindness and compassion in the way they supported them.

Experienced staff were knowledgeable about people's individual needs.

People had access to information about independent advocates to represent their views if needed.

People's privacy and dignity were respected by staff and independence was promoted.

Is the service responsive?

Good

The service was responsive.

On the whole information available to staff to provide a personalised and responsive service was in place. People received opportunities to participate in a variety of activities.

People and or their representatives, were involved as fully as possible in reviews and discussions about the care and treatment provided.

There was a complaints procedure available should people wish to complain about the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to check on quality and safety but these had not been used effectively as they could have.

People, relatives and staff raised some concerns about management and staff changes within the last 12 – 24 months affecting the service.

People, relatives and staff received opportunities to feedback their experience of the service.

Woodleigh Christian 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 comprehensive inspection was carried out on the 31 October 2017 by two inspectors, a specialist advisor who was a registered nurse and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service such as previous inspection reports, notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services for some people living at the service. We used this information to plan our inspection.

During the inspection we spoke with seven people who used the service and four visiting relatives. We also observed staff interactions with people as an additional method to understand people's experience of care and treatment. We spoke with the operations manager, the provider, the clinical lead (who was a nurse), four members of care staff, the cook and activity coordinator. We looked at care records relating to eight people living at the service. We reviewed other records relevant to the running of the service such as, staff recruitment records, quality assurance audits, staff training, staff duty rotas, meeting minutes and arrangements for managing complaints. During the inspection visit we spoke with two external healthcare professionals visiting the service.

Requires Improvement

Our findings

Individual risk assessments were completed to assess risks to people's health and safety such as falls, developing pressure ulcers and nutritional risk. Risk assessments were reviewed and updated monthly. The care plans for a person who was at high risk of falls and had fallen on many occasions previously, stated they walked with a frame and staff should accompany them when mobilising. However, this person was found not to always have their walking frame positioned near them and when they mobilised a staff member was either not present or did not provide assistance. Some people required equipment such as a pressure relieving mattresses due to a high risk of developing pressure ulcers. However, we saw the pressure relieving mattress for one person was not set at the correct weight for them. This meant the mattress would not be effective in reducing the person's risk.

The management of people's prescribed medicines required improvement. One person who used the service told us, "I got my tablets late yesterday. I don't usually take them until after breakfast but no-one brought them to me. I said to staff, 'I haven't had any tablets yet and it's 12 o'clock'. There was an agency nurse. This isn't the first time." A relative said, "They (staff) don't watch them [family member] take tablets, I've come in and seen their tablets still on the table."

Five people's medicine administration records (MAR) were missing staff signatures for some medicines for the day before our inspection visit and including the day of our inspection. There was no reason for these omissions recorded on the reverse side of the MAR chart which should be used to record this information. The senior care worker told us the night nurse had reported all medicines had been completed. However, we were not sufficiently assured that people had received their prescribed medicines.

One person had not received two medicines on 20 and 31October 2017. The senior care worker told us they were out of stock. After further checks it was identified additional stock had been received on 24 October 2017 and these were found in the medicine trolley. This meant there was no reason why this person should have not received their prescribed medicines. The error was due to inadequate audits and checks in place. The operations manager agreed this was an avoidable incident and improvements were required to reduce further reoccurrence.

We did a sample stock check of two different medicines which were prescribed to be administered as and when required. There was a large discrepancy for both of these medicines between the recorded and actual amounts of stock. No totals had been carried forward and therefore we were unable to identify when or why this had occurred.

The monitoring of temperatures in the medicine fridge and clinical room was inconsistent and had not been completed since 27 October 2017. In addition to this, medicines stored in the fridge, including eye preparations had not been marked with the opening date. This is important to ensure medicines are not used beyond their expiry date.

We found a person's prescribed drinks thickener in the communal kitchen area in a dining room in an unlocked cupboard. This is highly unsafe due to the risk if a person digested it. NHS guidelines and alerts have been issued to provider's to alert them of the requirement of safe storage. We also identified staff were not using people's individual prescribed thickener when required but used one thickener for all people that required it. This was inappropriate and did not follow expected and required prescribed medicine administration guidelines.

We found the door into the clinic room where medicines were stored had a slow door closure. When we entered the clinic room we found the keys had been left in the medicine trolley. This meant an unauthorised person could easily enter the room and could potentially have access to the medicines.

Weekly audits had been introduced in October 2017. These showed the same areas of concern we had identified. However, there was a completion date of 31 October 2017 to make the required improvements. Our findings identified these improvements had not been made.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had the required information to inform them of how people preferred to take their medicines. There were protocols in place to guide staff on the use of medicines to be administered as and when required. There was a medicine management policy and procedure available for staff and staff responsible for the administration of medicines had received appropriate training.

Some improvements were required with the deployment of staff. We received some concerns from people who use the service and relatives about staffing levels. One person said, "Sometimes staff take a long while to answer the buzzer. I've had to press it for assistance and had to wait 10 to 15 minutes." A relative said, "Sometimes [family member] gets a bit stressed as they've had to wait a long time to go to the toilet sometimes up to 20 minutes, that's my only criticism."

Staff felt there were sufficient staff available. One staff member said, "We're okay for staff, it's just when someone calls in sick. We do have a staff member 'on-call' who they (management) call in. We take it in turns to do on-call cover; it works out around once a month usually."

The operations manager told us staffing levels were based on people's dependency needs. They told us about the different shifts staff worked that had been introduced to reflect periods of greatest need. In September 2017 team leader roles had been introduced, the operations manager said this had increased accountability and responsibility and was proving a positive addition.

On the day of the inspection additional staff were available due to completing their induction. Therefore it was not possible to assess whether staffing levels were normally sufficient to meet people's needs. However, we did identify a concern with the deployment of staff. One person who was a known falls risk fell twice during our inspection whilst in a communal room. On one of these occasions a staff member was in the room but did not see when the person had got up and therefore was unable to provide assistance as per their mobility care plan. On the second occasion staff were not present. Staff told us no one had

responsibility to answer the call bells in the communal lounge and it was the responsibility of 'whoever was close by'. We observed frequent periods of people left without staff supervision. The delegation of staff roles and responsibilities of providing sufficient supervision to meet people's safety needed reviewing. We discussed this with the operations manager who agreed to take immediate action to ensure a staff member was present at all times in the communal area.

Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people. This included a criminal records check and employment history which helped the provider make safer recruitment decisions.

Staff had information available of the action to take should there be an event that affected the safe running of the service. This included a business continuity plan and personal evacuation plans for people. Clinical and moving and handling equipment was found to be available and in working order. Staff had received health and safety training and were aware of their responsibility to ensure the environment was kept safe at all times. There were audits and checks completed regularly of the environment and the registered / operations manager completed a daily walk around of the service that included a visual check of safety.

Staff were aware of the signs of abuse and their role and responsibility in protecting people from avoidable harm. One staff member said, "I tell them (management team) everything that I'm worried about and I know they report it. I once noticed that someone had a bruise when I came back from days off and I didn't know how it had happened. I told the manager but it had already been reported and investigated."

There was a safeguarding policy and procedure available for staff. However, we noted there was no information on display for people who used the service, visitors or staff of external contact details of the local authority safeguarding team, responsible for investigating safeguarding allegations. Records confirmed when there had been safeguarding concerns these had been reported appropriately to external agencies if required. All incidents were reviewed and analysed to consider what worked well, what could be improved upon and any action to reduce further risks. This meant there was a process in place to learn from incidents and make improvements.

Requires Improvement

Our findings

We received a mixed response from people who used the service and visiting relatives about the competency, skills and knowledge of staff. Reoccurring concerns were raised about newer staff employed at the service. One person said, "Some do (know what they're doing). The ones that are here any length of time." A relative said, "Yes I think the staff have the knowledge and skills to look after [family member] they're always talking to them and interacting with them." Another relative said, "Some do (have the skills and knowledge) and others don't. The new ones don't know."

Feedback from two visiting professionals told us on the whole they found staff to be knowledgeable. However, some concerns were raised about the use of agency nurses that had impacted at times on the continuity and consistency of care and treatment provided. The operations manager told us of their recent success in recruiting permanent nurses and the action taken to cover any shortfalls. This included using the same agency as far as possible and booking agency nurses in advance to address the issue about consistency.

We observed some new staff interacting with people in a way which showed a lack of experience and understanding of how to meet people's needs. For example, a person was unwell during the lunch time period, a staff member went over to them, put a glass of water on the table, but did not say anything or reassure the person or ask if they needed anything, and leisurely walked back to the sink area. We discussed this with the operations manager who agreed further training and support was required to staff recently employed without previous experience.

Staff told us about their induction, training and ongoing support. The operations manager told us the provider was in the process of changing their training provider and the new training programme was being launched the day after our inspection visit and included a plan of required training with due dates for completion. Records viewed confirmed what we were told. Examples of training staff had already been completed included moving and handling and fire training.

A member of staff we spoke with told us they completed moving and handling training before they were able to start working in the service and had received regular refreshers. However, we identified some inconsistencies with how staff supported people to transfer position with the use of a mobile hoist. For example, on some occasions staff were organised and followed best practice guidance that was safe and dignified for people. However, we also saw where practice could have been better. For example, we saw two separate occasions of staff using the hoist and were lifting people higher than required and moved people in

the hoist over a greater distance than was necessary or comfortable for them. We discussed this with the operations manager who agreed to discuss this with staff.

Staff told us they received opportunities to meet with their line manager to discuss their work, training and development needs. The provider had a supervision and appraisal policy and procedure that advised staff of the frequency they could expect to meet with their line manager. Staff records showed staff had not received supervision meetings at the frequency expected by the provider. The operations manager told us they were aware of this and had developed a staff supervision and appraisal plan. Records viewed confirmed this.

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

Care records stated people had consented to some aspects of their care such as the use of a sensor mat, (used for people known to be at risk of falls) but we did not see any signed consent forms or other records to confirm this. Where people lacked mental capacity to make specific decisions about their care and treatment care records showed mental capacity assessments had been completed. However, there was no best interest decision recorded to show who was involved and how decisions had been made and that less restrictive options had been considered. This meant this legislation was not being fully adhered to therefore affecting people's rights. The operations manager agreed action was required to address this issue and assured us they would take immediate action to address this

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 are called the DoLS. We checked whether the service was working within the principles of the MCA. Where concerns had been identified about a person's freedom and liberty, applications to the supervisory body for assessment had been made. Where people had been granted an authorisation this information was recorded in the person's care plan to inform staff. From the authorisations granted no person had any conditions attached to their authorisation.

We saw some care records for people who had a decision not to attempt resuscitation order (DNACPR) in place and found these to have been completed appropriately. Where people had lasting power of attorney that gave another person legal authority to make decisions on their behalf or if an advanced decision had been made, this information was recorded and staff informed. This meant that people's wishes were known and decisions planned for and staff had access to this information.

People received sufficient to eat and drink and were offered choices that met their preferences and considered their dietary requirements including religious or cultural needs. One person told us, "The food is A1! There's a choice and there are alternatives. They (staff) go out of their way." Another person said, "The food's okay. But we have to order the main meal the day before and I don't like that because I don't always feel like eating what I ordered yesterday." We shared this feedback with the operations manager. Following our inspection the operations manager sent us information confirming action was being taken to support people more effectively with their choice of meals.

We noted people were served a choice of drinks and snacks during the day of our inspection and additional, cold drinks, snacks and fruit were left in communal areas for people to help themselves.

The catering manager was provided with information about any special dietary requirements and we saw food for a person with lactose intolerance was clearly labelled as was food provided for people living with diabetes. The catering manager said, "If a person has been having problems with coughing and been referred to speech and language therapy the staff let us know. We adjust their diet, for example provide softer options and cut the meat into smaller pieces whilst we wait for them to be seen by SALT and we can follow their advice."

Nutritional risk assessments had been completed and nutrition care plans were in place. These provided staff with information on people's support requirements when eating and drinking and their individual preferences. People's weights were monitored for changes and action was taken such a referral to the GP if concerns were identified. Food and fluid charts were completed and when we checked past charts for three people, we saw they had achieved an adequate fluid intake. However, we saw that one person did not have any entries for food or fluid recorded on the day of our inspection when we checked at 2pm and another person had only been offered one drink according to their record. This suggested that food and fluid charts were not completed contemporaneously (accurate record, made at the time, or as soon after the event as practicable). A member of staff said, "The breakfast shift is punishing, trying to complete the breakfasts for everyone and fill in the charts." They said that people received breakfast and assistance, but the documentation may not always be completed in a timely manner.

People and visiting relatives were confident health needs were monitored and staff worked with external health care professionals to maintain people's health. One relative said, "Yes they (staff) look after (family member)'s health needs, they call the doctor, the optician and chiropodist if necessary."

We spoke with two visiting healthcare professionals. One told us they had some concerns with how staff managed people's diabetes care. The operations manager and clinical lead were aware of these concerns and said they were working with the support from external professionals to make improvements. We checked the knowledge of a nurse about diabetes and the management of two people's diabetes who had unstable blood sugar levels. This member of staff showed an understanding of the requirements and the particular issues related to the two people we discussed with them.

We reviewed the care records for one person who had diabetes and their daily blood sugar readings were high. There was a diabetes management plan in place which stated if the person's blood sugars were greater than a certain level their urine should be checked. There was no evidence in the person's care records this had been completed when it was required. The clinical lead explained there was a manufacturing issue with the testing strip and they had contacted the diabetes specialist nurse for advice. Whilst no interim care plan had been put in place to mitigate the risk for the person, nursing staff were aware of the action required to manage this situation.

Good

Our findings

On the whole people who used the service and visiting relatives spoke positively about the level of care provided and the staff approach. One person said, "Yes the staff are kind and caring and generally friendly." A visiting relative said, "The staff are friendly and yes they're caring."

Experienced staff were familiar with the people using the service and had a good knowledge of their preferences, routines, health conditions and nursing needs. We were aware seven new staff had recently commenced employment at the service. We spoke with one new staff member who said they had information available to inform and support them to meet people's needs. They told us experienced staff were supportive, but acknowledged their knowledge and understanding of people's preferences and routines would develop as they spent more time with people. One relative was complimentary about two new members of staff who they said had developed a positive relationship with their family member.

On the whole our observations of staff engagement with people were positive. People received kind care provided by polite and respectful staff. Staff provided people with reassurance and encouragement whilst supporting them to move, particularly when equipment was used. We heard staff giving people clear instruction when they were being placed in the hoist or using the stand aid. For example, we observed one member of staff ensuring that the person was comfortable before they started to move them. Staff were patient with people and responded courteously to people who called out to them repeatedly.

We saw examples where staff showed an interest in people showing that they mattered. For example, we heard staff complimenting people on their hair after they had visited the hairdresser, demonstrating a personal interest in people to boost their self-esteem. One person responded to the compliment by saying, "Do you think so? I always feel better when my hair has been done." We also saw some examples where staff were patient and respectful with people's communication needs. For example, we observed a member of staff trying to guess what a person wanted when the person was only able to say yes or no. They showed an understanding of the person and the things they might be trying to say and continued until they identified the person's wishes.

We heard one member of staff speak abruptly with a person. The person had been calling out to staff constantly and asking for a cup of tea and a sandwich prior to lunch. The member of staff responded by saying, "You can see we're busy, you'll have to wait." After lunch, staff asked one person if they were alright and they said no they wanted the toilet, the staff member continued to load the dishwasher then went and assisted the person. This showed a more task focussed approach than a person centred approach to care.

We discussed this with the operations manager who said they would ensure staff received further training and support in areas such as dignity in care and person centred approaches.

Some consideration had been given to people's communication and sensory needs. For example, we noted signage on toilets and bathrooms included braille to support people with sight impairment. However, we noted a small font typed menu was not displayed prominently for people to see. The day's choices were not provided in any other format to support people with sensory or communication needs. We discussed this with the operations manager who agreed action was required to improve how this information was made available for people.

People had access to information about independent advocacy services should they have required this support. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. There was no person who used the service that was currently being supported by an advocate.

People and visiting relatives received opportunities to be involved in discussions and decisions about how they received their care and treatment. This was informally and formally in the form of a six monthly review meeting. We saw examples of meeting records that confirmed how people and or their representative if appropriate had been involved.

People who used the service and visiting relatives were positive that staff were respectful with regard to dignity and privacy. Staff were able to explain to us the principles of good care. This included how they protected people's privacy and dignity when moving them by ensuring the were covered with a blanket when they moved them using a hoist to ensure their dignity. They also said they covered the person as much as possible when providing personal care and closed the curtains and bedroom door.

We observed people were offered regular comfort breaks and staff spoke quietly and discreetly with them to support their privacy and dignity. Bathroom doors were closed and staff checked the room was vacant by knocking and waiting before entering. People were referred to by their chosen name and staff we spoke with were aware of the name people preferred when it differed from their actual name.

We saw staff encouraging people to maintain their mobility and independence when they provided assistance to them. Relatives were able to visit their family member whenever they wanted to. We saw relatives visiting people throughout the inspection visit. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service. We found people's personal information was respected, for example it was managed and stored securely and appropriately.

Good

Our findings

Before people moved to Woodleigh Christian Care Home a pre-assessment of their needs was completed. This information was then used to develop care plans that informed staff of the person's needs and wishes. We saw examples of pre-admission assessments which had been completed with the person and or their relative or representative.

Included in the assessment was a consideration of people's diverse needs for example people's religious and cultural needs. This information was recorded to inform staff of what was important to people and what support they required. Staff gave examples of how people's spiritual or cultural needs were met. This included prayer meetings and opportunities for people to be supported with their individual spiritual needs and wishes.

We asked the operations manager how they met the needs of people who identified themselves as being lesbian, gay, bisexual or transgender [LGBT]. The operations manager told us they provided care and support that was based on a person's individual needs and preferences. They added that the service had a commitment in treating all people equally and without prejudice and discrimination.

People's care records contained information about people's life history and this provided a good level of detail about them, their family, previous employment and interests. Care plans contained details about people's care and support needs and details of their preferences in relation to their care.

We noted where people experienced periods of anxiety or agitation or who sometimes resisted care, care plans gave staff information about the action they should take and ways to gain the person's cooperation.

People's care records mostly provided the necessary information for staff. However, information lacked detail in some areas of people's care. For example, when people were at high risk of developing pressure ulcers their care plans did not contain instructions for staff to assist them to re-position at regular intervals to prevent pressure ulcers developing. However, when we checked people's daily records we saw they were generally being assisted to re-position at two to four hourly intervals, which meant they did not suffer any impact from this omission. The operations manager told us they had already identified care plans required reviewing and amending, to ensure they contained all required information for to staff to provide effective and responsive care. The operations manager said they had a plan in place to complete this work and records viewed confirmed action was underway.

People who used the service and visiting relatives were on the whole positive care was based on people's individual needs. One person said, "I've no concerns. If I needed someone they're (staff) there. I just have to ask." A relative said, "[Family member] uses a wheelchair and when they (staff) help them move they use a rotunda and there's two of them." Another relative said, "[Family member] is able to have a bath here. They have a jacuzzi bath with lots of bubbles and they enjoyed it." A newly admitted person said they had "felt a bit embarrassed", when a male staff member had helped them wash and dress. They said the member of staff had been very professional and appropriate and they would feel more comfortable with it in the future. We discussed this with the operations manager who agreed to take action to reduce this situation from reoccurring.

One relative raised some concerns about how their family members care was met. We discussed this with the operations manager who said they would arrange a meeting with the person and their relative to discuss their concerns and how improvements could be made. Following our inspection the operations manager forwarded us information confirming what action they had taken.

We observed examples of staff being responsive to people's requests. For example, a person told us they did not want the food on offer and was going to call the local fish and chip shop. We heard staff offering to do this for them.

We received a mix response from people who used the service and visiting relatives about the activities available. One person said, "There are activities if you want to. I like playing scrabble and sometimes I play it with a staff member." Two relatives felt the activities could be improved upon. One relative said, "I don't know if there are enough activities. [Family member] has joined in with chair based activities when they have them." Another relative said, "They probably could do more activities, there are long periods when they don't do anything. There's choir tonight, that's every week and [family member] can sing; they're doing a concert at Christmas."

We saw information available about a variety of activities that were provided that included, regular prayer meetings, community based tea in the local church, visits to a community 'dementia cinema', pampering sessions, reading newspaper aloud, dominoes and quiz afternoon and external entertainers also visited. The service had two activity coordinators who arranged and provided activities. One activity coordinator told us, "I provide one to one opportunities for people every morning, where I will spend some time with them, including people who remain in their room and in the afternoon we provide group activities."

We observed there was classical music playing during the day in one of the communal areas. There were magazines on small tables in the lounge; however we did not see anyone looking at them or being encouraged by staff to do so. We observed the activity coordinator sitting with two people and showing them a book which provided opportunities to remember different smells. For example, we saw them provide a person with an opportunity to smell eucalyptus and asked them what it reminded them of. After lunch the activity coordinator spent time with two people and supported them to play a game of dominoes. Before tea people were asked if they would like to go and sing with the services choir. We saw people happily joining in.

People's uptake of the activities was recorded in their care records, we saw examples of activities people had participated in that included external entertainers, chair exercises and art and craft opportunities. A ring binder of activity photos was available for relatives to view and this showed people taking part in seasonal parties, enjoying visits from pets and being taken out to see the Christmas lights. The folder provided evidence that activities were provided regularly throughout the year.

Complaints were listed to and acted upon. Some people and relatives told us that they had raised issues with the management team and that these had been dealt with to their satisfaction. Staff were aware of the complaints policy and what their responsibility was in relation to this. Records confirmed complaints were investigated as per the provider's complaint policy and procedure, action was taken and outcomes recorded.

Requires Improvement

Our findings

Whilst the provider had a system of regular audits and processes in place that checked on quality and safety, these required some improvement to ensure the service met people's individual needs. During this inspection we found the checks in place that monitored the management of people's medicines had been ineffective.

Before our inspection we had been informed by external healthcare professionals of some concerns in relation to how clinical needs were met. Whilst some improvement had been made in how people's clinical needs were assessed and met, this required further improvement to ensure safety, consistency and continuity of care, particularly in relation to diabetes care. In addition to this, we also noted there had been a recent situation that arose where the service did not have a replacement catheter bag available when one was required. This demonstrated a lack of communication and organisation.

Whilst the operations manager responded to our concerns highlighted during the inspection about the presence of staff in communal areas to meet people's safety needs, this had not been previously identified. This inspection also identified where people lacked mental capacity to consent to specific decisions, there was a shortfall in how best interest decisions were made. This showed there was an issue with understanding of the action required to ensure the Mental Capacity Act 20015 was fully adhered to.

People who used the service and visiting relatives told us staff and management changes during the year had been unsettling. One relative said, "There's instability of staff, I want familiarity, quite a few of the established staff have left." Another relative said, "There's been changes in the hierarchy, a succession of different managers who didn't stay very long." Despite this, we were told that recent changes had been positive. A relative said of the operations manager, "The manager is very approachable, she was calming and didn't judge me, she made a good impression on me."

There were quarterly meetings for residents and relatives to give feedback about the service and an annual satisfaction survey was due to be sent to people, relatives and external professionals and staff. A relative confirmed this by saying, "They (management team) send round questionnaires occasionally asking you about the care." In addition, the operations manager said a suggestion box had recently been introduced. This meant the provider invited people to give feedback about the service in a variety of methods.

Some staff reflected on the frequent changes in management in the past two years and how this had been unsettling for staff and had affected morale. Staff spoke positively about the registered manager whom they

described as approachable and fair. They said the registered manager was always contactable by telephone when they were not on duty. One staff member said, "They've been great at supporting me. They're very good here and always check that you're alright."

The operations manager told us staff meetings were arranged quarterly and that the last meeting date was May 2017. A member of staff said they were encouraged to put forward new ideas or a better way of doing things but they did not have a specific means of putting ideas forward currently. They said, "We don't get the opportunity to sit down together and discuss issues."

The operations manager told us as a method to improve communication within the service; there were daily, "Flash" meetings with heads of departments to discuss current issues and challenges and another flash meeting for care staff. A staff member said, "We have handover at the beginning of the shift and a meeting at 11.00am so we can tell them (nurse/ team leader in charge) how the shift is going and if there's anything we're worried about." We observed the morning staff handover meeting where there was an exchange of information about people's needs and appointments for the day and action that required following up.

The clinical lead said they could obtain clinical advice and support from the specialist nurses who visited the service regularly; however, they did not have formal arrangements in place for clinical support and supervision. We discussed this with the operations manager who agreed to address this issue.

The provider was meeting their registration regulatory requirements. A registered manager was in post. The provider had notified us of certain events they are required to do and the previous inspection rating was displayed correctly.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with their care and support staff did not always follow guidance. People were not protected from risks associated with the environment. Medicines were not always properly and safely managed. Regulation 12 (1) (2) (b) (g) Medicines were not always properly and safely managed. Regulation 12 (1) (2) (g)