Manorville Care Homes Ltd

Manordene

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Manordene on 4 and 8 August 2017 and the inspection was unannounced. Manordene is a care home which provides personal care and accommodation for up to 22 adults who are elderly, physically disabled or have dementia. On the day of our inspection there were 21 people living at the service. Manordene is located on a quiet residential road in West Kingsdown.

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

On the first day of our inspection staff appeared rushed. On the second day of our inspection when an extra staff member was shadowing a shift staff appeared to have more time to support people. Some call bells were not answered in a timely fashion and the provider did not have a dependency tool to determine staffing levels.

Care records were not consistently maintained. We found some records relating to fluid intake and output had not been completed meaning peoples could be at risk of dehydration.

Quality audits had not consistently identified shortfalls in service delivery highlighted in our inspection. Other audits had been completed and had led to improvements being made.

Care plans did not always contain accurate information about people to enable staff to care for the person. One person had a skin condition that required treatment that was being provided but had not been addressed in their care plan.

People were not always kept safe at Manordene. Medicines were not being stored at the recommended temperature and fluid thickener that poses a choking risk to people was left out unattended. We have made a recommendation about this in our report.

Activities did not always take in to account people's interests past and hobbies and were not always meaningful. We have made a recommendation about this in our report.

People were kept safe from abuse at Manordene. Staff told us they understood the importance of people's safety and knew how to report any concerns. Risks to people's health, safety and wellbeing had been assessed and plans were in place, which instructed staff how to minimise any identified risks to keep people safe from harm or injury.

People received their medicines when they needed them. Medicine profiles were in place which provided an overview of the individual's prescribed medicine, the reason for administration, dosage and any side effects.

The registered provider had effective and safe recruitment procedures in place and staff told us that they had the training they needed to carry out their roles.

Staff treated people dignity and respect. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. People's privacy was respected by staff who valued people's unique characters.

Staff were kind and caring good interactions were seen throughout our inspection, such as staff sitting and talking with people as equals and treating them with dignity and respect. People could have visits from family and friends whenever they wanted.

Complaints were used as a means of improving the service. People felt confident that they could make a complaint and that any concerns would be taken seriously.

There was an open, transparent culture and good communication within the staff team. The management team offered effective leadership to the service.

The registered manager took an active role within the service and led by example. There were clear lines of accountability and staff were clear about their roles and responsibilities.

The registered manager had notified us of events that had occurred within the service so that we could have awareness and oversight of these to ensure that appropriate actions had been taken.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers 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.

The provider had not ensured that staffing levels were consistently sufficient to provide care and support to people.

Medicines were not being stored safely and we found a fluid thickener that had not been stored safely. People received their medicines when they needed them.

The provider had ensured that the service was well maintained carrying out appropriate safety checks and servicing.

People were protected against abuse by staff who had the knowledge and confidence to identify safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records for monitoring people's health were not always completed accurately. We found fluid charts and mattress settings were not being recorded.

Staff had access to a full training programme and told us that they felt well trained.

People had access to adequate food and fluid to meet their needs.

The principles of the Mental Capacity Act 2005 (MCA) were applied in practice.

Is the service caring?

Good

The service was caring.

People spoke very positively about staff. People and relatives told us they were happy with the service they were receiving.

Staff had good knowledge of the people they supported. Staff communicated in ways that were understood by the people they

supported.

People's privacy and dignity was respected by staff.

People told us that they and their relatives were involved with their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities were not personalised for people's interests and past hobbies.

Some care plans did not contain personalised information about people's medical conditions.

Complaints were being monitored and were used as a tool to improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits had not highlighted all shortfalls in service delivery, such as the high temperature in the medicines room and personal information missing from some care plans.

The registered manager provided effective leadership to the staff and was an active presence in the service.

The service promoted a homely culture where staff promoted peoples independence where possible.

Manordene

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 8 August 2017 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As some people who lived at Manordene were not consistently able to tell us about their experiences we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, six care staff, eight people and four people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at six people's care plans, medication administration records, risk assessments, accident and incident records, maintenance records, complaints records, two staff files and quality audits that had been completed.

We last inspected Manordene in August 2015 and rated the service as good.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Manordene. One person told us, "I feel safe: there is always someone to chat to, like the laundry girl, the kitchen girl, and the manager, because they check on me and pop in if I stay in my room." Another person commented, "It's excellent I had been in hospital a long time and I feel safe here. There are lights on around you at night and I've never even thought about not being safe." One relative told us, "Yes, [loved one] has been there three years and we've always been extremely pleased with the way they're looked after. We arrive any time unannounced and we always find them well looked after: clean, healthy and their room is lovely and staff are fantastic. If we couldn't visit I wouldn't worry as they would keep [loved one] safe and keep us informed." However, despite these positive comments we found some areas of practice that were not consistently safe.

We received mixed feedback from people, staff and relatives around the level of staffing in the service. One person told us, "I don't have to wait a long time for help, they're really good here." However, another person commented, "I need two people to help me but the longest I've ever had to wait is half an hour." One relative told us, "We've always thought there was enough staff and haven't seen people calling out. We're more than happy: there always seems plenty of staff." However, other people, staff and relatives felt that staffing levels were low. One person told us, "Sometimes I wait an hour to get in to bed. I press the call bell but they can't leave the patients. During the evening I'm lucky if they come quickly." Another person said, "There's not really enough staff, carers are put under pressure every day." One relative commented, "I don't think there are enough regular staff, especially if they are teaching an agency staff and then they still have their jobs to do." One staff member told us, "There are not enough staff: they're all high need patients and all double hoist and I think there should be an extra, floating staff. Everyone needs two to help them hoist and the nurses are too busy to help with care tasks." Another staff member commented, "There aren't enough staff and people's dependency is higher now than two years ago."

We spoke to the registered manager about staffing levels and were told that the service does not use a dependency tool. Staffing levels at the time of our inspection were set at four care staff in the morning with one nurse, three care staff with one nurse in the afternoons and two carers with one nurse at night times. The registered manager explained that as resident numbers had increased the staffing levels had been raised. The registered manager told us, "Previously we only had three staff and one nurse in the mornings and one nurse and carer at night times."

We reviewed the call bell data for the week prior to our inspection which showed longer waiting times in the afternoons when three care staff were on shift. The call bell times showed that a very high majority of calls in the week preceding our inspection were answered in less than five minutes, and the majority of these were answered in less than two minutes. However, in the period from 24/07/17 to 29/08/17 we found one call took 20 minutes 39 seconds to answer, and one call took 18 minutes and 6 seconds to answer. 15 calls had taken longer than five minutes to answer and of these 13 were in the afternoon or night time.

On the first day of our inspection, when there was the normal staff allocation of four care staff and one nurse on shift in the morning, we observed staff appeared to be rushed, did not have the time to be

interviewed by inspectors and were struggling to respond to people's needs. We noted that some people had an odour of urine and spoke to a staff member about this who told us, "It is because pads aren't changed. We're making our way through taking people to the toilet or to be changed. We do need more staff on." On the second day of our inspection, when an additional staff member was on shift to shadow, we observed care provided to people using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed 12 people in the lounge during and after breakfast. Five care workers were on shift with one nurse. We observed good interactions between staff and people and people's needs were met. For example, when two people needed assistance to use the toilet they were helped appropriately. One person fell asleep on their books and was led to a more suitable chair. Another person called for help and a care worker arrived after three minutes and was given a lot of reassurance and attention. One staff member checked people who were sleeping in their chairs to make sure they were comfortable, and adjusted a foot on a foot plate and brought a blanket for another person.

The registered provider did not have a systematic approach to determine the number of staff required in order to meet the needs of people using the service and keep them safe at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's medicines were not consistently being stored safely. Medicines were being stored in a separate locked room with a portable medicines trolley and a lockable cabinet inside the room for medicines that require additional secure storage. We noted that the room was very hot and checked the room temperature records. The Royal Pharmaceutical Society of Great Britain's guidance, 'The handling of Medicines in Social Care', states, 'Some storage rooms become too hot for medicine storage unless there is good ventilation or an air conditioning unit. If the temperature is more than 25°C, it is too hot.' For the period 01/08/17 to 08/08/17 the lowest temperature reading was 28 degrees centigrade: on the day of the inspection the temperature was 30 degrees centigrade. We asked the nurse what the temperature of the medicines storage room should be and were told, "No more than about 24 or 25 centigrade". We asked whether the registered manager was aware of the temperature of the room and whether action had been taken and were told, "Yes they are aware, someone came and tried to reduce the temperature, but it's getting hotter again. An engineer came out about two months ago." We checked the temperature of the medicines fridge and found that temperatures exceeded the recommended temperature for refrigerated medicines. We spoke to the registered manager about this and asked them to take urgent action. The registered manager ordered a portable air conditioning unit to be delivered the following day. The registered manager spoke to the pharmacist who supplied medicines to the service and the pharmacist confirmed that the medicines would be OK if the air conditioning unit was installed the following day. Subsequent to our inspection the registered manager confirmed that the temperature in the medicines room had returned to safe levels.

During the inspection we found that a prescribed fluid thickener, which is used to thicken drinks to help people who have difficulty swallowing, was left in open reach of people. It had been left on a trolley in the dining room during the food service. Prescribed thickeners should be kept locked away to prevent accidental ingestion of the powder. A patient safety alert had been cascaded by NHS England in February 2015 which warned care providers to the dangers of ingesting thickener. We raised this issue with the registered manager who arranged for the thickener to be moved to the locked medicines cabinet.

We recommend that the registered manager implements ongoing monitoring systems and takes action as required to rectify any shortfalls.

People's medicines were being administered safely. Medicines were administered by registered nurses on set daily rounds from portable medicines trolleys. Good administration practices were observed: staff

checked the medicine, person, route and dosage before offering the tablets to people with a glass of water. The registered nurse locked the medicines trolley whenever they were not using it to ensure that people and medicines were safe. The service used a monitored dosage system where tablets arrive from the pharmacy pre-packed and in a separate compartment for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted correctly, meaning that audits of medicines were being conducted accurately and regularly. MAR charts had been signed correctly to indicate that people had received their medicines.

People were protected against the risks of potential abuse. The staff members we spoke with told us they had undertaken adult safeguarding training within the last year. Staff members had a clear understanding of their role in safeguarding people from abuse and in the processes involved in reporting concerns. Staff had received training in safeguarding vulnerable adults and were able to speak with confidence about the subject. One staff member told us, "If I suspected any abuse I would report it to the nurse in charge and then manager. If there wasn't any action I would then go further to social services." There was a safeguarding file kept at the service which contained the local authority safeguarding adults policy, protocols and guidance. The registered provider had a safeguarding policy which referenced the up to date definitions of abuse, such as modern slavery. Incidents that met the threshold for reporting to the local authority safeguarding adults team had been made appropriately and logged on to a monitoring sheet.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. A range of risk assessments were in place to ensure that staff were instructed how to minimise these hazards. These included risk assessments for people who were unable to use their call bells, who had bed rails in their bedrooms, who displayed behaviours that challenge, who were at risk of falls, malnutrition or skin damage. Control measures to reduce the risks included hourly checks, distraction techniques, sensor mats in or outside people's bedrooms, fortified diets, and equipment such as air mattress and specialised cushions.

Environmental risks were being managed effectively through regular monitoring and checks conducted by the registered manager. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. The registered manager ensured that general risks such as slips and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Fire safety measures were in place and all equipment and risk assessments had been checked and assessed regularly.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. We checked four staff files and found that criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided photographic proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "I think there's enough training. I can't do anything on my own and they help me well." Another person commented, "They [staff] get enough training to help me. I need to use the hoist and they get me out of bed every day." A relative told us, "The staff know how to look after X. They are like nurses because they are experienced. They see things quickly, for example, they know when X has a water infection even before it's been tested and they can get treatment. They've done this on quite a few occasions." However, despite these positive comments we found some areas of practice that required improvement.

People's health care needs were not always met effectively. Some people at Manordene had pressure wounds which required air mattresses. Staff checked people's body temperature, pulse, blood pressure, weight, body mass index (a way to help you figure out if you are at a healthy weight for your height) and Waterlow score (a way to indicate whether people are at risk of skin damage) on a monthly basis, or sooner when there were any concerns. Checks of mattress settings were recorded, on a form that indicated, 'Staff need to do daily checks to ensure mattress is inflated and what pressure it is set on depending on resident's weight and recommended air mattress setting'. However, as there was no information regarding people's individual weight and of the setting parameters staff were unable to check properly whether settings were correct. Staff had ticked the forms to indicate the settings were correct without accurately checking. This meant that some mattresses may be incorrectly set and could compromise people's skin integrity. We requested to see turning charts for people with skin integrity issues and saw that 'PC' was being recorded to indicate 'position change'. However, records we reviewed stated that the person was required to have hourly position changes during the day time and two hourly at night but we found these were not being recorded. For example on 04/08/17 there were only three entries of 'PC' in a 24 hour period. In addition, there was no indication of what position a person had been changed form or to which meant the person could be at risk of being frequently turned to one side. The registered manager subsequently informed us that the time stated on the turning chart of repositioning every one or two hours was incorrect. The person had not suffered skin breakdown but the lack of accurate recording posed a risk to the person.

Other health checks were not being recorded. A system of individual clipboards had been introduced to record when staff checked on people's wellbeing; checks that their call bells were within reach; food and fluid intake charts; bowels charts; bathing / showering / washing charts. These charts were checked twice daily and signed by the nurse. However, we found that not all checks were being completed consistently. One person had a urinary catheter fitted and had a medical condition that required monitoring of fluid intake and output. A urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag. The monitoring sheet for the person required staff to complete fluid intake and fluid output to monitor their underlying medical condition. We checked records for 03/08/17 to 06/08/17 and found that fluid output had only been recorded twice. During this same timescale we found a gap of 15 hours and another gap of 12 hours where no fluids had been recorded as given. On three of these days no totals had been recorded to check if the person had received the amount of fluid they required. We checked with the nurse on duty who told us, "X has a catheter so we measure fluid input and output." Some people's bathing records had not been fully completed with up to 14 days blank entries in one month.

The failure to maintain an accurate, complete and contemporaneous record in respect of each service user is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had the training and skills they needed to meet people's needs. One staff member commented, "The training is very good and regular. I haven't needed to request anymore training: the management would give you it if you asked for it though." Another staff member told us, "There's quite a lot of training and I'm looking forward to the challenging behaviour training next week. The training is very thorough and we get questions about it and have to write down our understanding of the training." Staff were up to date with essential training that focused on health and safety, falls and wound prevention, infection control, manual handling, and mental capacity. Staff had been provided with additional training to effectively meet people's individual needs such as, dementia care and end of life care. Newly recruited staff studied to gain the care certificate. Several care staff had gained or were studying for a diploma in social care and all staff received regular one to one supervision sessions and were scheduled for an annual appraisal of their performance. Nursing staff received regular clinical supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had ensured that people's freedom had not been restricted unnecessarily and that systems were in place to keep people safe. People's mental capacity was assessed appropriately in relation to simple decisions relating to their daily care and routine. When people had bed rails in place, appropriate steps had been taken to ensure they had the mental capacity to take this decision and were able to consent to this. More complex decisions, such as choosing a place of residence, were taken by the local authority in collaboration with the registered manager and people's legal representatives and families, when people had been assessed as not having the relevant mental capacity. Appropriate applications to the DoLS office had been made for people who may need to be deprived of their liberty as they were unable to come and go unaccompanied and without constant supervision.

People told us they liked the food and were able to make choices about what they had to eat. One person told us, "I have always enjoyed what I've had to eat here and if you can't finish it it's OK. Supper last night was coated chicken, potatoes and peas." Another person said, "The food is excellent. You can always have more if you want it: you never go hungry here and there's always a drink available. You can have a coffee whenever you ask, it's no problem." One nurse told us. "The food is good. We eat what is not served and it tastes good and smells appetising." The cook kept a list of people's likes and dislikes, such as one person not liking pasta or another person preferring hot deserts. There was accurate information about people's different dietary needs: one person was on a soft diet and this was displayed alongside information about people's food allergies. Each day the kitchen assistant visited people to ask what they would like for their meal from a menu choice. We observed people telling the kitchen assistant how much they had enjoyed their meals the previous days. Staff encouraged people to drink throughout our inspection One person commented, "They [staff] are always telling me I need to drink more and they explain the problems that not drinking causes."

Good

Is the service caring?

Our findings

All the people and their relatives we spoke with told us that they liked the staff and described them as kind. Comments included, "They [staff] are very kind, very nice people and very patient", "The staff are very attentive and go to people who don't ask for them: they see if people are having problems without being called over" and "The staff are caring and your everyday needs are met. They are always popping in to see if everything is alright or if you need anything." One relative commented, "The staff are caring we arrive at different times and they all seem lovely. X is double incontinent and is clean and the staff treat her with respect. She has her hair done regularly." Another relative told us, "They [staff] are genuine and honest. They're all friendly to me when I arrive and I know them quite well from all my visits: if they weren't caring I would have moved my [loved one]."

We observed very open, familiar relationships between people and their staff and these were apparent throughout the inspection. One person was having a hand reading session with a staff member and there was an easy flow to the conversation, punctuated by shared laughter. The person asked the staff member, "What does this line on my palm mean?" The staff replied, "It means you've got plenty of energy." The person joked, "I wish I could show it" and enjoyed the joke with their staff. The session brought about lots of different conversations ranging from the person's history and jobs they used to do, to family. As the session ended the person said, "You're very easy to talk to" and the staff member thanked the person for the compliment and said they were going to share the compliment with their family when they got home. This was typical of the warm and friendly manner in which people and staff spoke to each other during our inspection.

Staff were mindful of how people felt while they received care. One person had spilled a drink on their clothing and was reassured by a care worker who came to her aid, in a way that dispelled any embarrassment, saying, "Don't you worry, just a little mishap, we'll put that right in no time." The person was hoisted by two care workers who provided explanations of what they were doing ensuring the person was not distressed but felt secure, engaging in conversation with her during the procedure. Another person had called for help with their personal care and a care worker was heard to say, "No problem, I am here to help, we'll get that done together", after having knocked on their bedroom door and announced themselves as they entered.

People received support from thoughtful staff who were kind and gentle. One person living with dementia liked to have soft toys nearby. One staff member had found a lamb toy and had returned it to the person. Over the course of the next hour we observed four different staff members engaging with the person. Each staff member sensitively spoke with the person, asked questions about the lamb and told the person how lovely it was and used the same language as the person to refer to the soft toys, which the person appreciated. When people were sleeping in their rooms, staff checked on them gently as not to wake them up, and woke them up softly when they needed repositioning. People were checked at regular intervals throughout the day and night and these checks were documented. A person had been provided with a large 'V' cushion as they preferred a certain angle when sitting. Staff members were heard saying, "Sorry to wake you, would you like a cup of tea?", "Try to have some breakfast you need some energy" and "Another

spoonful, are you ready" when supporting people. Bathing and showering charts indicated people were offered a bath or a shower daily. One person preferred to have a bed bath, and this was provided.

People's privacy and dignity was respected by staff. Staff took care to pull the blinds and close bedroom doors when they helped people with their personal care. Care plans were kept locked away in a cabinet to ensure people's personal information was stored securely. We observed staff members knock on people's doors before entering and that people were confident to tell staff members they didn't want to see them, and staff respected this. One relative told us, "They take everything in to consideration with my aunt, when she is moved or has personal care, and they are the same with other residents: they show them respect." Where people were at risk of having their dignity compromised staff were sensitive and caring and ensured that people were protected. For example, one person living with dementia had been incontinent and did not want to leave the communal area. Two staff members had discreetly but unsuccessfully tried to encourage the person to accompany them for personal care. Another staff member arrived, and gave the person some time to settle before asking them to help with a task. This re-direction of the person's attention enabled staff to discreetly assist the person and maintain their dignity.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. We saw that during annual reviews and care plan reviews people had the opportunity to be involved and their opinion was listened to. One staff member told us, "If people are able to make a decision we always involve: what do you want to eat or drink or wash their face I believe in making people more independent." We reviewed care plans and saw that where people could they had signed their care plans. Where people lacked the ability to have direct input to their care plans, opinion had been consulted from the staff team and peoples loved ones or friends in order to capture the person's wishes and preferences. One relative told us, "Day to day decisions X is involved in but for bigger decisions they always ring me up. I was quite happy with response to an accidental injury recently. I've been invited to social events and to review the care plan with the local authority. If I wanted to look at care plan or query anything they would let me see it."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to their needs. One person told us, "If I tell staff I don't want to get up, they go: they're good here" and "The staff get me up whenever I want: maybe I'll join the others downstairs this afternoon." One relative commented, "When I'm there I can see they know my aunt and her beliefs and take that in to account. They know she's very religious: they won't be disrespectful about anything she says and are respectful to her beliefs and the church visit her." One staff member told us, "If people are able to say what they want we listen, or some people will say they don't want male carers and we respect that and make sure it's a female carer who supports those people." Despite these positive comments we found that some areas of practice were not responsive.

Care plans did not always contain information that enabled the staff to monitor the well-being of the person. One person was being cared for in bed. When we visited them we noticed that they had very dry skin. The care worker supporting the person told us, "X had dry skin and we cream them [with moisturising lotion] every time we wash them." However, their care plan did not contain a reference to their dry skin issue or how to effectively treat it. The same person had been diagnosed with a condition that could affect the way they function as the condition progresses. This condition had only been mentioned in passing in the person's mental health plan but was not addressed or explained further in their care plan.

There was a limited range of activities on offer, which did not take into account people's individual interests. For example, four afternoon a week activities were 'Fun with your care team'. We asked a person what this meant and they said, "I have no idea. Sometimes they sing, or they put the TV on but it's always on." One person's life history indicated they enjoyed farming and favoured a particular classical violinist although no activities had been planned around this person's interests. Another person's activities care plan had been evaluated by staff and indicated that the person had only watched television, without indication that any options were offered as an alternative. A person told us, "We are bored, there isn't much to do", and another said, "There is something every day but it is not very exciting, and nothing at weekends. Most of the time we just sit around and we talk with each other or watch some TV".

During our inspection, the activity of the day was two church volunteers coming into the service to sing a hymn with people, and a church service. One person told us, "That was nice but quite short, they've already gone." There was no activities provision for that morning for people who did not want to observe a religious service. We spoke to care workers about activities provision. One staff member told us, "There's not enough activities there and in the afternoon people look bored and some say to me I'm bored I want to go to bed. You can see they're bored and are bored with the TV but after lunch if they had a bit of entertainment it would be so much nicer for them. They don't do a lot in the mornings sometimes. We don't get to take people out only very occasionally unless relatives take them out: it's only the activities lady who takes people out." Another staff member said, "There's not enough that goes on and they need more interaction in the afternoon then they wouldn't be so withdrawn or looking so bored. They need something more to keep them occupied and with staffing we're struggling as it is."

The failure to ensure that each person has an accurate and personalised plan and to ensure that people

have a range of meaningful activities that are tailored to their interests is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Comprehensive assessments of people's individual needs were carried out before people came into the home. Care plans were developed that addressed safety, breathing, personal and oral hygiene, eating and drinking, communication, mobility, continence, sleeping, skin, and behaviours. Particular attention was paid to communication as how to communicate with people or interpret their body language was included in care plans. For example, in a personal hygiene care plan, staff were instructed to adjust their pace to the person's pace, prompt and give options to a person and allow them time to process the information. In a nutrition care plan, staff were instructed to provide encouragement as the person was unable to express when they were hungry or thirsty. A care worker told us how staff managed a person's toileting needs when at times the person displayed behaviour that challenged. They told us, "We accompany the person to the toilet regularly but it is often not productive and a little disheartening but we keep trying and give plenty of encouragement, we understand [X] cannot help [a particular behaviour], and we must respect this, and give him as much dignity as possible; we check the skin for any moisture lesions, any rash, we apply cream, and only use pads in between regular trips to the toilet," These instructions were in the person's care plan and implemented in practice.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service recorded all complaints in a complaints log and these had been followed up in line with the registered provider's complaints policy. We reviewed a sample of complaints and found that the registered manager had ensured that learning was put in place from any shortfalls in service and issues were resolved. For example, one complaint had been logged around the response of staff at the weekend when a person had requested assistance to use the toilet. As a result the registered manager had investigated to find to what had happened and addressed the issue in a staff meeting. One relative told us, "We've never had to think about complaining. We had to ask for X's nails to be cut once and that was addressed straight away they were doing it as we left."

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke about the registered manager in positive terms. One person told us, "I've been here for many years and she [the manager] knows me pretty well, she often comes and chats with me." Another person said, "The manager comes round every day to see if everyone is alright." One relative told us, "The management is good everyone seems to be on the ball and the management seems spot on." Another relative commented, "I think [manager] is lovely, very good and very up on everything." One staff member told us, "If the manager sees something is wrong she'll take you to one side and tell you: firm but fair." However, despite these positive comments we found some areas of practice that required improvement.

The registered provider did not have effective systems in place to monitor the quality of care and support that people received. Despite quality auditing systems being in place some shortfalls that have been highlighted in our inspection had not been identified and put right, such as high temperatures in the medicines storage room, personal information not being included in care plans and fluid thickener being left out unattended.

The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

Other quality audits had been completed by the registered manager which had been effective in identifying improvements. The registered manager completed an audit of care plans, falls, infection control, kitchen and food, medicines and cleaning. The registered manager told us, "After the audits I give feedback. For example, for the kitchen audit I meet with the cook and she will generate an action plan. This is the same with the care plan audit where I feedback to each nurse about their allocated care plans. It works because people know I'm checking and keeping an eye on things and it improves the service." The registered manager also audited quality through relatives and service user feedback surveys. One relatives survey had a comment, "I feel satisfied my mother is being looked after very well." The comment went on to describe the physical and mental progress made by their loved one. Staff surveys were largely positive with staff feeling supported in their role.

The registered manager provided effective leadership, was an active presence in the service and understood the needs of the service well. The registered manager explained that their leadership style was 'firm but fair'. The registered manager told us "I am a nurse and have the experience and knowledge of the job and what it entails. People respect that and that I'm not afraid to get involved; they understand if I ask them to do something that it comes from experience." A visiting GP told us, "The manager is very helpful and she comes down to help. Sometimes if staff are sick she helps out." The registered manager described being an advocate for people and staff and saw their role as having responsibility for providing and equipment or training that people or staff need. The registered manager told us, "It's important to keep the service safe and be responsive to people's needs, staff training and recruiting new staff when we need to. I only know these things if I'm out on the floor, seeing things and talking to staff." The registered manager described how they used the performance management and disciplinary procedures when required in order to maintain high standards. We discussed an incident where a person was injured due to a staff member not following

the correct procedure. The registered manager had investigated, followed the disciplinary procedure and dismissed the staff member. The registered manager explained, "There is a process we go through and we would always look to offer support and training to staff."

The service promoted a positive culture that was person-centred, open and inclusive. One relative who was a regular visitor told us, "They are always quite happy and pleasant and there's a nice atmosphere. I'm always happy to go there; it's not a place I dread going and everyone is always chirpy and nice." Another told us, "It's always good mixture of staff of different ages some younger and middle aged: the staff are all lovely. The cleaner's and laundry staff are always perky and chatty and it's all very positive." The registered manager commented, "The culture of the home is that because it is so small it is a personal service. The carers and residents know each other very well and have built up relationships with each other which is important." The registered manager spoke about having an open door policy and encouraging honesty and transparency. The registered manager involved the staff with any changes such as starting shift times an hour earlier as people wanted to get up earlier in the mornings. The registered manager told us that they supported staff as part of the nurturing culture in the service, "I check nurses PIN (a PIN is a number given to registered nurses when they register with the Nursing and Midwifery Council) and assist with re-validation if needed. One nurse was having problems with the re-validation process so I helped her through it."

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The locality manager confirmed that no incidents had met the threshold for Duty of Candour.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that each person has an accurate and personalised plan and to ensure that people have a range of meaningful activities that are tailored to their interests

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user. The registered provider had failed to ensure that quality monitoring was effective in highlighting shortfalls in service delivery.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager had not implemented a systematic approach to determine the number of staff required in order to meet the needs of people using the service and keep them safe.