Care Quality Commission

Tamaris Healthcare (England) Limited

Lea Green Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection which we carried out on 23 April 2015.

We last inspected Lea Green Court in April 2014. At that inspection we found the service was meeting all its legal requirements.

Lea Green Court is a 45 bed care home that provides personal and nursing care to older people, and people with dementia and physical disabilities.

A manager was in place but at the time of inspection they had not yet become registered as their application was still being processed by the Care Quality Commission(CQC). 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.

Due to health conditions and complex needs not all of the people who used the service were able to share their views about the support they received.

Summary of findings

People said they felt safe and they could speak to staff as they were approachable. We had concerns however that staff on duty were not always appropriately deployed to provide safe and individual care to people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People received their medicines in a safe and timely way. However we had concerns about some aspects of medicines management.

Not all areas of the home were clean and well maintained for the comfort of people who used the service.

Equipment was not always available to meet the needs of people who used for the service.

Staff undertook risk assessments where required and people were routinely assessed against a range of potential risks, such as falls, mobility, skin damage and nutrition.

Staff were provided with training to give them some knowledge and insight into the specialist conditions of people in order to meet their care and support needs.

Regular staff knew people's care and support needs. However care records we looked at were not all up to date. They lacked evidence of regular evaluation and review to keep people safe and to ensure all staff were aware of their current individual care and support needs. Detailed individual information was not in place to help staff provide care to people in the way they wanted.

People had access to health care professionals to make sure they received appropriate care and treatment.

Communication was not always effective to ensure the well-being of people who used the service.

People did not always receive a varied and balanced diet. We recommended that the provider seeks relevant guidance from a dietician or food nutritionist to assist with menu planning.

People said staff were kind and caring. However we saw staff did not always interact and talk with people when they had the opportunity. There was an emphasis on supervision and task centred care.

There was a programme of entertainment and activities provided by the activities person, however when they were not available, other staff did not provide activities for people to remain stimulated. Relatives we spoke with said more activities and stimulation needed to be provided for people.

People and their relatives had the opportunity to give their views about the service. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

The home had a quality assurance programme to check the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received individual care that met their needs.

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

We found five breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in relation to medicines, equipment, safety, environment and care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of the service were safe.

Although people told us they felt safe we found systems were not in place to ensure their safety and well-being at all times.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

People's medicines were not always managed appropriately.

Staff were not always appropriately deployed to provide individual care to people.There were systems to ensure that new staff were suitable to work with vulnerable adults.

There was not always a good standard of cleanliness.

Equipment was not always available to provide the necessary support to the person.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were supported to carry out their role and they received the training they needed.

Communication did not always ensure the necessary information was passed between staff to ensure people received appropriate care.

Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

People did not receive a varied and balanced diet to meet their nutritional needs. Special diets were catered for.

The building was designed to meet the needs of people with dementia but the environment was showing signs of wear and tear in several areas.

Is the service caring?

Requires improvement

Most aspects of the service were caring.

Staff were kind and caring but there was an emphasis on task centred care as some staff did not spend time talking with people or engaging with them.

We found people were helped to make choices and to be involved in daily decision making. However their meal time experience needed some improvement.

There was a system for people to use if they wanted the support of an advocate.

Summary of findings

Visitors said they were involved and kept informed about their relatives care and any change in their condition.

Is the service responsive?

Requires improvement

The service was not always responsive.

Regular staff were knowledgeable about people's needs and wishes. However, people did not always receive support in the way they needed because staff did not have detailed guidance about how to deliver their care.

Written information was not available for all people to make staff aware of the person's individual preferences, likes and dislikes.

People had limited opportunities for activities when the activities organiser was not available.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires improvement

Not all aspects of the service were well-led.

A manager was in place who was in the final stage of registration with CQC at the time of inspection. Staff and relatives told us she was supportive and could be approached at any time for advice and information.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. Therefore the quality assurance processes were not effective as they had not ensured that people received safe care that met their needs.

Lea Green Court 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 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 23 April 2015 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

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

We undertook general observations in communal areas and during mealtimes.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. During the inspection we spoke with 11 people who lived at Lea Green Court, five relatives, the manager, the deputy manager, a registered nurse, five support workers, a domestic and two members of catering staff. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and all bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for eight people, the recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams and three other professionals who were able to comment about the care provided. We received information of concern from these agencies which we followed up as part of the inspection.

Requires improvement

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Relative's commented, "The staff are always checking (Name),"and, "I like to come in, I know they (staff) are busy, I think they need more staff."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found concerns had been logged appropriately. A number of individual safeguarding alerts had been received about people's care, they had been investigated by the local authority where required and the necessary action had been taken by the provider to address the concerns.

Staff had some understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the manager. They told us they had completed the organisation's safeguarding e learning training on the computer. Staff were able to tell us how they would respond to any allegations or incidents of abuse and were aware of the lines of reporting within the organisation. However, they were not all aware of the multi-agency safeguarding procedures and the role of each agency when an alert was raised. They told us they were aware of the provider's whistle blowing procedure and knew how to report any worries they had. One staff member said, "I'd feel comfortable raising any concerns."

Before the inspection we had received some concerns with regard to staffing levels, the numbers of nursing staff on duty after 2:00pm and the "turnover" of nursing staff. The manager and managing director told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. At the time of inspection there were two nurses and seven care workers on duty to care for 35 people. We were told by the manager after 2:00pm the nursing level would reduce to one nurse. On the day of inspection there were two nurses until 3:00pm. One nurse commented, "Now it's dropped to 1.5 nurses over the day, I'm not really confident. It's hard in the afternoon, after 4:00pm there's no time to evaluate. If there are lots of multi-disciplinary visits there's no time for care plans." Another nurse said, "I feel confident practising here, only two out of five, if it was rated. I've explained this to the home manager and the regional manager. One's accountable for everything and everyone when you're in charge. I hope something will be done."

On the top floor which accommodated 18 people, some of whom lived with dementia and cognitive impairment support was provided by: one nurse, one senior care worker and three care workers.

On the ground floor which accommodated 17 people, some of whom lived with dementia and general nursing needs, support was provided by: one nurse and three support workers.

Staff told us, and the person's care records showed that one person on the top floor received 1:1 supervision from staff during the day because of their care and support needs. We observed the person did not receive 1:1 care at all times. When other staff were not available one staff member supervised all the people in the lounge. This was particularly noticeable before and during lunch when staff were busy elsewhere with people and also when staff were writing records or taking their break. We had to intervene and inform the staff member about two people in the lounge who required some support. As, the staff member was also supporting the person who required 1:1 support, this left other people who required support unsupervised. The person also became agitated in the dining room as they had to wait whilst the staff member supported other people to eat. We did not see nursing staff provide practical support to people on the top floor when care staff were busy or they went on their breaks.

On the ground floor after lunch one staff member was left to supervise people in the lounge. We saw one person went into the bedroom of someone confined to bed. However, the staff member had to balance whether to remain with the people in the lounge who required supervision or leave them, to remove the person from the bedroom and check on the person who was confined to bed. We observed they managed to coax the person out of the bedroom without leaving the lounge.

We were told by the managing director there were sufficient staff on duty as the numbers had been allocated, according to a dependency tool. This dependency evaluation tool was used as a tool to calculate staffing levels. However dependency evaluations were not all updated monthly to check people's current care and support needs. We had concerns the staff on duty were not effectively deployed to ensure people always received safe and individual care.

Requires improvement

Is the service safe?

We checked the management of medicines. People had 'medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. We observed a medicines round and saw the worker remained with each person to ensure they had swallowed their medicines. Medicines records were mostly accurate and supported the safe administration of medicines. There were no gaps in signatures and the medicine records looked at showed they were signed for after administration.

We had concerns however with certain aspects of medicines management. Medicines were twice left unattended in the trolley between administrations. The CQC specialist advisor was present and reminded the person of the importance of locking the trolley to ensure people did not have access to an unlocked trolley and this was actioned. The system for controlled drugs (controlled drugs are medicines which may be at risk of misuse) was checked and appropriate arrangements were in place for their administration, storage and disposal. However a random check of the controlled drug stock showed that the balance documented did not tally with the quantity of drugs available. The staff member who had witnessed the controlled drug administration immediately signed the register and checked with the other staff member elsewhere in the building to rectify the situation.

There was written guidance, for the use of "when required" medicines, and when these should be administered, such as for pain relief. However, this guidance was not detailed to provide staff with a consistent approach to the administration of this type of medicine and when it should be given. For example, two records stated, "For wheezing/ asthma" and "for pain", and did not give any other details so staff would know when to administer the medicine.

Records we looked at showed one person received covert medicine. Covert medicine refers to medicine which is hidden in food or drink. The record documented the General Practitioner, next of kin and nurse had discussed the need for the covert medicine, as the person did not have mental capacity. However, there was no evidence the pharmacist had been involved in the decision and the record did not document when the decision was made. We saw the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Records showed that risk assessments for areas such as tissue viability, nutrition, falls and swallowing were in place to reduce the risk to people's safety. However they were not regularly reviewed and evaluated to ensure people received safe care and treatment that met their current needs. For example, we saw falls, nutrition and a choking risk assessment that were not up to date.

This was a breach of regulation 12 (2) (a) of the Health and Social Care Act 2008. (Regulated Activities) 2014.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility. This was to be used if the building needed to be evacuated in an emergency.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references, one of which was from the person's last employer. Confirmation from the Disclosure and Barring Service (DBS), which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

The registered provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Records we looked at included; maintenance contracts, the servicing of equipment contracts, fire checks, gas and electrical installation certificates and other safety checks. Regular checks were carried out and contracts were in place to make sure the building was safe.

However, not all equipment was in working order. Before the inspection we received a concern from a visiting

Requires improvement

Is the service safe?

professional. They had visited the service to carry out an assessment of a person who was nursed in bed. The hoisting equipment was unable to be used to transport the person from bed, as the batteries were not charged for the hoist required to assist with the movement of the person. This meant specialist equipment was not always in working order and available to be used to meet the care needs of people who used the service. We were told by the manager a battery was available. However, staff were unaware of its location and they had not informed the manager the visiting professional was in the building, so they could advise them of its location.

We saw some people's bedrooms did not have a nurse call bell or any equipment for people to summon staff if they needed assistance when they were in their room. We were told by the manager this was because they were unable to use a nurse call or they may be at risk of using the cord of the call bell as a ligature. However, records looked at did not contain an assessment about people's capacity to use them. This meant people were at risk as they could not summon staff in an emergency and equipment was not always available to each person to keep them safe.

Not all areas of the home were clean. There was a malodour around the home. The corridor floors appeared dirty and the skirting boards were dusty. The bedrooms were not all clean despite checking later in the day after the cleaning routine. Furniture, skirting boards and heater sills were dirty, sticky and marked in some bedrooms. The carpets in some bedrooms were also marked and stained. The flooring in some en-suite and communal lavatories required replacement for effective infection control. For example, the linoleum around some lavatory pedestals was discoloured and lifting from the base.

This was a breach of Regulation 15 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service effective?

Our findings

Staff had some opportunities for training to understand people's care and support needs. Staff comments included, "Training is available," and "There's loads of training." However, two nurses commented they needed more opportunities for practical training. One nurse said, "We need to keep our clinical competencies up to date and need more training." Another said, "We need more training about medicines, venepuncture, (the collection of blood from a vein), syringe driver and Percutaneous Endoscopic Gastrostomy (PEG) training. (PEG is a tube which is placed directly into the stomach by which people receive nutrition, fluids and medicines).

The staff training record showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included; dementia care, distressed behaviour, catheter care, conflict resolution, palliative care, pressure area care and equality and diversity. They had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Nurses and support staff said they felt supported and could approach the manager at any time to discuss any issues. One person said, "I feel supported, the manager is very approachable." Support staff said they received regular supervision from the senior support worker every two months and nurses received supervision from the manager. Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs.

CQC monitors the operation of DoLS. DoLS are part of the MCA. These are safeguards put in place to protect people from having their liberty restricted without lawful reason. We checked with the manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that a number of applications were being considered and four people were currently subject to such restrictions. This meant people's human rights were being protected.

Records showed assessments had been carried out, where necessary for people's mental capacity to make particular decisions. For example, with regard to their health care.

People did not comment positively about the food and the complaints log we looked at recorded complaints from relatives about the food. Comments included, "Pilchards on toast, for lunch is not very substantial." and, "There's loads of corned beef." Another relative said, "There's not much variety for (Name) on their soft diet, there's lots of mashed potato." Other people said the food "could be better", and "it's so so." Another person also commented, "There aren't many salads." We had concerns when we saw the lunch served was cheese sprinkled over chips or spam and beans. It was not well presented and did not look appetising. The cook told us the main meal was in the evening and it was to be corned beef hash. However, this was not reflected on the menu which advertised soup and sandwiches. We observed the potatoes for the evening meal were deep fat fried so people were receiving two lots of fried potatoes in one day. The menus showed people did not always receive a varied and balanced diet. For example, menu choices available for one day showed minced pie and chips for lunch and cheese pasty for tea time. Another day the menu advertised cheese chips or jacket potato for a teatime meal. For two days in succession a meal option was corned beef hash. We did not see evidence of home baking,(cakes and biscuits) although menus advertised a selection was served at afternoon drink time. Drinks were available during the day. However, we had concerns all people did not receive extra drinks to keep them hydrated in the hot temperature which we recorded as 84 degrees Celsius to the top floor.

The cook told us special diets were catered for and they received information from nursing staff when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about

people, as well as the daily care entries in people's individual records. The nurses told us a handover of verbal and written information took place between the nurses for each shift.

We had concerns however with regard to the communication amongst staff as it was not always effective to help ensure people's care was not compromised and to ensure people had access to the equipment they needed.

Care staff commented, "Communication could be better." "We don't always get told what's been happening when we've been off. For example, I didn't know someone was now diabetic and I could have given them a biscuit," and, "As I'd been off it was three days after coming back to work before I found out someone had died." Another staff member said, "Other care staff usually tell me what's been happening." A visiting professional was concerned at not being able to complete a second specialist assessment for a person, for a specialist chair, due to the failure in communication within the home when they arrived with a team to complete the assessment. Two other health care professionals commented information was not always effectively passed from one nurse to another with regard to a change in a person's treatment, or when passing on instructions for staff to follow with regard to healthcare support. A recent safeguarding alert had also highlighted there had been a delay in a person receiving an additional prescribed medicine due to the prescription not being collected in a timely way. One of the professionals commented this may be due to the turnover of nursing staff and the use of agency staff who do not work regularly at the home to provide consistency and continuity of care to people.

People's health care needs were mostly met in a timely way. The General Practitioner (GP) told us about the specialist care home support team which held a clinic one afternoon each week in the home. The team comprised of a GP, specialist nurses and a nurse from the home. Areas discussed included; emergency health care plans, do not attempt resuscitation decisions (DNAR) and laxative medicines. The clinic was held to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital.

However, a health professional commented that the appropriate action was not always taken when specialist advice and assessment was provided to obtain specialist equipment for a person. For example, with regard to the specialist chair for a person with spasticity and choking problems or a particular sling for moving and assisting a person. We were told the advised equipment was not obtained on these two occasions and substitutes were provided that were not appropriate to meet the person's needs. Safeguarding alerts had been raised as a result of these concerns and action was being taken by the provider.

This was a breach of Regulation 15 (1) (e) (f) HSCA 2008 (Regulated Activities) Regulations 2014.

The environment was designed to help people with a dementia related condition to maintain some independence. The premises were 'enabling' to promote people's independence, and involvement. Corridors were decorated and had pictorial displays and items of interest to help people engage and be stimulated as they moved around. People were able to identify different areas of the home. There was appropriate signage and doors such as lavatories, bathrooms and bedrooms had signs for people to identify the room to help maintain their independence. Memory boxes contained items and information about people's previous interests and they were available outside people's rooms to help them identify their room. They also gave staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves.

We had concerns not all areas of the home were well-maintained for the comfort of people who lived in the home.

The building in some areas was showing signs of wear and tear. Paintwork was scuffed and chipped on skirting boards and doorways in some areas including corridors and bedrooms. Some bedrooms had no secondary lighting other than the main light and the person would have had to get up from bed to turn it on. Some bedroom walls were marked, a ceiling in another bedroom was discoloured. A set of drawers in one bedroom did not close. The curtains in a bedroom were hanging off the rail. All bedrooms were personalised. However, the bedding in several rooms showed it was not substantial enough to keep people warm in cold weather and help them enjoy comfortable bed rest. Some sheets were worn and discoloured in appearance and duvets were thin, bedding was creased and crumpled. Pillows were also flat or lumpy. Therefore people did not all have comfortable and well maintained bedrooms.

Requires improvement

Is the service effective?

This was a breach of Regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We recommend that the provider takes advice from a dietician or food nutritionist to help with menu planning.

Requires improvement

Is the service caring?

Our findings

People who lived in the home and their visitors were positive about the care provided by staff. People commented, "The staff are kind." And, "The staff are hardworking." Comments from relatives included; "The staff are all good, they are friendly." And, "The staff are committed.", "The care staff are mostly the same as when (name) was first admitted here, I think they are caring." "The staff are very caring, I think they keep (name) cleaned and bathed." Health professionals, who visited people at the service, also told us they found the staff team to be caring.

Staff engaged with people in a calm and quiet way. When they carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. Care workers were caring and patient. For example, they talked gently to a person and reassured them as they asked them if they wanted some help to stand up. One said, "Don't worry we'll look after you." We saw as the nurse administered people's medicine, she explained and told them what the medicine was for.

From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person. Staff did not take every opportunity to engage and interact with each person and provide an atmosphere of awareness and interest in surroundings. On the ground floor some staff, although they were sitting supervising people, did not engage with them. They did not take the opportunity to talk to people and spend time listening to what they had to say. We observed some people also remained in their bedrooms without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them. People who were more able to communicate verbally received more interaction from staff, as they engaged with staff for their attention. For example, staff members when they were in the lounge upstairs talked with some people who were there.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two plates of food and two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People's privacy and dignity was respected. Staff knocked on people's bedroom doors before they entered and could give us examples of how they respected people's dignity. For example, people were asked if they had a preference for a male or female carer to carry out personal care tasks with them.

We saw the lunchtime meal in the two dining rooms. Care workers were busy as they served meals and supervised people to eat in dining rooms, bedrooms and lounges. The dining experience could be improved as it was not well organised. Dining tables were not set before meals and people had to wait for cutlery. Condiments and napkins were not available. The choices of food were not advertised on the menu boards which were displayed so people would have been aware of what was being served before the meal. On the second floor the meal started with two care workers in the dining room to support nine people, including the person who required one to one assistance. One care worker was left to provide supervision, support and encouragement to the remaining five people who were still eating or being encouraged to eat their meal. This included the person who required one to one support. Staff provided prompts of encouragement in a quiet and unhurried way, however they did not always notice when people needed assistance. On the ground floor the meal time was noisy and we intervened to obtain help for a person who was having difficulty managing their food. A person in the lounge was asked if they wanted some lunch and when they declined they were not encouraged or offered an alternative. Another person who had their meal in their room was also not offered encouragement or an alternative when they left their food as staff were not available to check and provide support and encouragement if required.

There was information displayed in the home about advocacy services and how to contact them. Advocates can

Requires improvement

Is the service caring?

represent the views and wishes for people who are not able to express their wishes. No one had an independent advocate at the current time as people had relatives involved.

Family members told us they were kept informed about any changes in their relative's condition. One relative said, "They (staff) keep me up to date with any changes." Others commented, "Staff keep me informed when I visit the home," and, "The home keep me informed of anything they think I should know."

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, an emergency health care plan was in place for a person that showed a "best interest" meeting had taken place with the person's family and the GP. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Requires improvement

Is the service responsive?

Our findings

People commented there were some activities and entertainment. Relative's comments included, "They have regular outings and often there is a singer here, but really they need more conversation," and, "The staff made an effort at Christmas, they decorated the home and dressed up for the occasion." Another person commented, "People need more activities." A person said, "I like going out for lunch." Another said, "I like going to the pub for a pint."

An activities organiser was employed who arranged a programme of entertainment and activities. Records showed these included singers, visits from animals and local school children. People told us the activities person also arranged outings to the local pub for lunch. The hairdresser visited regularly and church services also took place. We did not see a programme of daily activities advertised which could have taken place when the activities person was not on duty. At the time of inspection the activities person was not at work and we did not see staff provide activities for people during the day except for a member of staff playing dominoes with one person. Music was playing in the afternoon in the upstairs lounge which people enjoyed.

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Records confirmed that preadmission assessments were carried out.

Record keeping for people was not consistent. Up-to-date written information was not always available for staff to respond to people's changing needs. Some annual risk assessments, such as for moving and assisting and falls had not been reviewed since February 2014. Records showed that monthly assessments of people's needs were carried out but they did not always reflect the changes that had taken place. For example, with regard to pressure area care for one person and nutrition for another person.

Staff knew the individual care and support needs of people, as they provided the day to day support, but this was not always reflected in people's care plans. The care plans did not give staff specific information about how the person's care needs were to be met. They did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. People therefore did not have individual and specific care plans to ensure consistent care and support was provided.

Some people with distressed behaviour were referred to the behavioural team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people's behavioural plans to help staff provide care to the person. However, care plans were vague, or not in place for some other people who may show agitation or distress. For example, care plans stated, "Gets anxious needs reassurance." The care plans did not give staff detailed instructions with regard to supporting people when for example personal care was carried out. Information was not always available that included what might trigger the distressed behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour. Risk assessments and care plans were not in place to advise what staff should do and when a referral to a specialist behavioural team would be triggered if people refused to accept any assistance or refused to carry out their own personal care. We were told by the manager a new care plan system was being introduced which would make it easier for staff to follow as care plan evaluations were to be separate from the care plans.

Some people had a social profile but it was not available for everyone. The information had been collected with the person and their family and gave details about the person's preferences, interests and previous lifestyle. It is important information and necessary for when a person can no longer tell staff themselves about their preferences.

We found records did not all accurately reflect people's care and support needs with guidance for staff to deliver care and support in the way the person wanted.

This was a breach of regulation 9 (1)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example; the dietician was asked for advice with nutrition. Staff completed a daily diary for each person and recorded

Requires improvement

Is the service responsive?

their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans that were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home.

People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained. 19 complaints had been received since September 2014 which had been investigated and the necessary action taken. One relative said, "I know how to complain if I needed to." Another said, "I made a complaint to the manager."

Requires improvement

Is the service well-led?

Our findings

A manager was in place who was in the process of registering to become registered manager with the Care Quality Commission (CQC) at the time of inspection. The registered provider had been pro-active in submitting statutory notifications for serious injuries and safeguarding incidents.

Staff said they felt well-supported. Comments included, "The manager is supportive" and, "I enjoy working here, the new manager is very approachable." A relative commented, "I find the new manager very approachable, and they often come to talk to me when I am visiting."

Staff told us regular meetings took place and these included head of department meetings, general staff and nurses meetings and health and safety meetings. They were held to keep staff updated with any changes within the home and to discuss any issues. Meeting minutes showed recent meetings had discussed communication within the home, staff performance, the environment, cleanliness, people's care and record keeping.

Relatives told us meetings were held for people and relatives. A relative commented, "There are regular relative's meetings, which are very useful, I wish more relatives would attend. We were shown a dvd about how care was delivered in the homes." Another relative said, "I know they take place but I don't usually attend."

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people. A relative told us, "I was sent a questionnaire to fill in about the home." We saw copies of the surveys of the quality assurance survey for December 2014 which had been sent out to everyone in the service. The manager told us the results were analysed by head office. We saw findings from the survey were positive but comments about activities did not score as well as other domains.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. Although records were audited monthly and included checks on care documentation and staff management, these audits had not highlighted deficits in certain aspects of record keeping. This included care planning, social profiles and risk assessments to ensure they contained accurate and detailed information so people received care in the way they wanted and needed.

Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. However the environmental audit was not always effective as it had not ensured that all areas of the building were decorated and had a good standard of cleanliness. The registered manager told us monthly visits were carried out by the regional manager to check on the quality of care being provided by the service. A financial audit was carried out by a representative from head office annually. These were carried out to ensure the care and safety of people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.** **People who used the service were not protected against the risks associated with unsafe care and treatment and the proper and safe management of medicines. Regulation 12 (2) (a)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014.** **Premises were not all clean and well maintained. Equipment was not always available to meet the needs of the people who used the service. Regulation 15(1)(a)(e)(f)**

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 **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.** **Records did not accurately reflect people's care and support needs with guidance for staff to deliver care and support in the way the person wanted. Regulation 9(1)(3)(a)**