

Blackrod House Limited

Blackrod House

Inspection report

Chorley Road
Blackrod
Bolton
Lancashire
BL6 5JS

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 17 January 2017 and was unannounced. The last inspection was undertaken on 26 August 2015 when the home was rated as Requires Improvement. At that inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the provision of safe care and treatment.

Blackrod House is registered to provide accommodation for up to 30 people. A unit for people with varying stages of dementia is located on the first and second floors, while residential care is provided by the unit on the ground floor. The home is situated on the corner of the main road through the centre of Blackrod, near Bolton. Local shops and amenities are close by.

There was a registered manager at the home. 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.

At this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to good governance, person-centred care and requirement to display ratings. You can see what action we told the provider to take at the back of the full version of the report.

Record keeping was poor and risk assessments were not always included within the care plans. Although there was no evidence to say that anyone had suffered harm, the lack of appropriate guidance for staff around how to mitigate risks could potentially place people at risk of significant harm.

Care records were inconsistent and did not include all appropriate care plans. Where people's choices with regard to care were documented, these choices were not always respected. This meant that, although the care we observed was delivered kindly, people were not always receiving care according to their preferences and wishes.

The current CQC ratings were displayed near the front door of the premises. However, the ratings were not displayed on the website.

Audits were undertaken but the quality of some of the audits was poor. Care plan audits had failed to identify gaps in the records, so improvements to these records were not being made.

People told us they felt safe at the home and there was an appropriate safeguarding vulnerable adults policy in place. Staff we spoke with had a good working knowledge of the safeguarding procedures.

The service had emergency plans in place and emergency equipment was maintained and serviced

appropriately.

Recruitment of staff was robust and staffing levels were sufficient to meet people's needs. The service had a robust induction programme and training for staff was on-going.

Infection control procedures were followed and there were appropriate medicines systems in place to help ensure medicines were given safely.

The environment included signage to assist with orientation and there were tactile objects, a sensory room and a reminiscence lounge for people to use.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA).

People told us the staff were caring and we observed friendly and patient interactions between staff and people who used the service throughout the day.

We saw that people were encouraged by staff to do what they could for themselves. This helped promote independence.

Appropriate information was given to people who used the service and their relatives. We saw that people were encouraged to be involved in their care planning and reviews of care and regular customer satisfaction questionnaires were sent out.

There were a number of activities within the home as well as regular trips out. There was a well-equipped sensory room and a reminiscence lounge for people to use.

The complaints procedure was displayed within the home and in the service user guide. There had been no recent complaints.

There was a registered manager in place. People who used the service and their relatives told us the registered manager was approachable.

Staff supervisions were undertaken regularly and staff meetings took place on a regular basis. Appropriate policies and procedures were in place and these had been reviewed and were up to date.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Risk assessments were not always included within the care plans and therefore staff did not have appropriate guidance to mitigate the risks.

People told us they felt safe at the home and there was an appropriate safeguarding vulnerable adults policy in place. Staff had a good working knowledge of the safeguarding procedures.

Recruitment of staff was robust and staffing levels were sufficient to meet people's needs. Infection control procedures were followed and there were appropriate medicines systems in place to help ensure medicines were given safely.

Requires Improvement ●

Is the service effective?

The service was effective.

The service had a robust induction programme and training for staff was on-going.

The environment included signage to assist with orientation and there were tactile objects, a sensory room and a reminiscence lounge for people to use.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA).

Good ●

Is the service caring?

The service was caring.

People told us the staff were caring and we observed friendly and patient interactions between staff and people who used the service throughout the day.

We saw that people were encouraged by staff to be as independent as possible.

Appropriate information was given to people who used the

Good ●

service and their relatives. People were encouraged to be involved in their care planning and reviews of care and regular customer satisfaction questionnaires were sent out.

Is the service responsive?

The service was not always responsive.

Care records were inconsistent and did not include all appropriate care plans. Where people's choices with regard to care were documented, these choices were not always respected. This meant that care was not always delivered in a person-centred way.

There were a number of activities within the home as well as regular trips out. There was a well-equipped sensory room and a reminiscence lounge for people to use.

The complaints procedure was displayed within the home and in the service user guide. There had been no recent complaints.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Audits were undertaken but the quality of some of the audits was poor. Care plan audits had failed to identify gaps in the records, so improvements were not being made.

There was a registered manager in place. People told us the registered manager was approachable.

Staff supervisions were undertaken regularly and staff meetings took place on a regular basis.

Appropriate policies and procedures were in place and these had been reviewed and were up to date.

Requires Improvement ●

Blackrod House

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.

The inspection took place on 17 January 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC).

Prior to the inspection we looked at information we held about the service such as notifications, safeguarding concerns and whistle blowing information. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

Before our inspection we contacted Bolton local authority commissioning team to find out their experience of the service. We also contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care.

During the inspection we spoke with four people who used the service and three relatives. We also spoke with four members of care staff and the registered manager. We used a 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 talk with us. We reviewed records at the home including eight care files, four staff personnel files, meeting minutes, training records, health and safety records and audits held by the service.

Is the service safe?

Our findings

We asked people who used the service if they felt safe. One person said, "Yes, I feel safe". Another told us, "I wasn't safe at home, I kept falling, but I'm safe here". A third person commented, "I feel it's a safe place to live. The staff are always checking to see that I am alright". We spoke with relatives about safety. Comments included; "My [relative] has had a few falls in the past and they always phone me to let me know. They seem to respond very well and there is a sensor alarm in the bedroom to monitor his mobility" and "I feel [relative] is safe and I feel that also when I leave after a visit".

We looked at eight care files and saw that each one included a personal emergency evacuation plan (PEEP). This is a document which outlines the level of assistance that would be needed in the event of an emergency. There was a 'grab file' near the front door which included a copy of each PEEP for easy access should they be needed.

We looked at how risk was documented within the care plans. Each care plan we looked at contained risk assessments in relation to falls, waterlow (for skin), nutrition and use of equipment. Where risks were identified, there was appropriate guidance to follow as to how risks were to be mitigated. For example, if people were deemed to be at high risk of falls, appropriate referrals had been made to the falls clinic through the GP which was documented in each care plan we looked at under the professionals involvement section. However, not all potential risks had been identified within the risk assessments and care plans.

We were told of a recent incident where a person had managed to exit the home. The exit they had used had now been secured. However, this person had previously displayed behaviours that challenged the service and stated their wish to leave. The individual had not been at the home long and documentation had, as yet, not been completed. We were told that the GP and mental health team had been asked to assist with this person, but the lack of documentation in the form of an individual risk assessment made it difficult to determine how further potential risk and behaviour was being managed day to day and whether staff had clear guidance in place on how to manage this.

The staff told us this person had, until recently, required the supplement 'Thick and Easy' due to being at risk of choking, although this had been recently discontinued. It was unclear who had discontinued this or why. Despite this previous risk, care plans and risk assessments in relation to choking, when the thickener was in place, had not been implemented, to show how these risks were being managed.

We looked at the care plan for another person whose eating and drinking care plan described them as having a cough when eating and swallowing. Due to this, staff needed to observe them as they were at risk of choking. The care plan was dated May 2016, and had been reviewed each month, stating there was 'No change' to this person's care needs. We were told that this had been a short term care plan and the person's cough was no longer an issue. Therefore this care plan should have been updated as discontinued with reasons for the change.

We found that one person living on the dementia unit had lost weight in recent months and we saw the

home had appropriately referred this person to the GP for further advice and the GP had been out to visit this person at the home. The GP had stated they didn't have concerns and that the weight loss was related to their health condition, but advised to offer higher calorie food options and to continue to monitor the individual. This person's eating and drinking care plan did not make any reference to this advice and only stated this person had a poor appetite and liked certain foods such as scones and cornflakes. There was no guidance for care staff around facilitating a fortified diet and monitoring any change and it was unclear if high calorie foods were actually being given.

There was also a lack of guidance in care plans for staff to follow about how much fluid people needed to drink each day and the records only referenced 'Pushing fluids'. Where fluid charts had been completed staff only recorded if a quarter or half of the drink had been consumed, with no overall totals for the day. These also weren't signed off by staff to check if the fluid each person had taken was enough. We did, however, see that drinks were available for people during the day and at meal times. People were regularly offered hot and cold drinks by staff throughout the day.

We looked at how the home cared for people who were at risk of developing pressure sores. We saw each person had a waterlow risk assessment in place, which determined the risk of people developing skin breaking down. At the time of the inspection, we were told there was nobody living at the home with a pressure ulcer, although one person had recently developed a 'Moisture Lesion'. This is where the skin may become damaged by excessive moisture.

Despite this concern being raised, a skin integrity care plan had not been implemented by the home to make staff aware of the concerns regarding this person's skin. We observed this person to be seated on a pressure relieving cushion in the lounge area; however this was not documented in the care plan as being a requirement for staff to follow. This person had been appropriately referred to the district nursing team by the home due to concerns and we saw records on this person's file to show they visited regularly. Their advice had been to apply cream four times each day and we were able to see from the MAR charts that staff did this consistently, although again, there was no care plan information about this and it was only referred to in the professionals involvement section.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of appropriate documentation, we saw staff implementing measures to mitigate risks to people. There were referrals to appropriate health professionals and appropriate equipment, such as pressure relieving cushions, was used. However, the lack of documentation could have resulted in people not receiving the level of support required to mitigate risks.

We looked at four staff personnel files and found that the recruitment process was robust. The files included job application, job description, photo identification, two references, interview notes and Disclosure and Barring Service (DBS) checks. DBS checks help ensure people's suitability to work with vulnerable people. We saw that the service followed their disciplinary procedures when necessary. Appropriate risk assessments had been carried out for staff members who were pregnant, to help ensure their safety at work.

There was an appropriate safeguarding vulnerable adults policy in place, which had been reviewed recently. Staff had undertaken safeguarding refresher training recently and those we spoke with were able to demonstrate an understanding of safeguarding issues and how to report them. One staff member said, "I've done recent safeguarding training. Some of the types of abuse that can occur include emotional, physical, and financial. Signs to look out for are crying, bruising, changes in behaviour and generally not being

themselves. I would document everything and report it straight to the manager". Another told us, "I wouldn't hesitate to report abuse. I'm aware we can contact the police and CQC as well".

We saw that the service had responded to recent feedback from professionals by providing training in catheter care for all staff. This demonstrated a commitment by the service to responding to suggestions and advice appropriately.

We looked at the whistle blowing policy which included relevant information and guidance and staff were aware of the policy and confident to report any poor practice they may witness.

We saw that accidents and incidents were documented within people's individual files. If someone had suffered repeated falls, or scored highly on the falls risk assessment, this was followed up with a referral to the falls team.

Since the last inspection a new call bell system had been installed so that people could alert staff if the required assistance. We were told that some individuals, particularly on the dementia unit, suffered from cognitive impairment and it was the culture within the home to maintain frequent checks on everyone. The call system records every check. There was also a night shift frequency matrix and pressure mats and infrared motion sensors were integrated within the call system. This could have been made clearer in the care plans.

On the day of the inspection there were sufficient staff in place to address the needs of the people who used the service. The registered manager told us that an extra staff member was added if someone had an appointment and needed staff to accompany them. This meant they did not leave the home short of staff.

Rotas were planned with regard to numbers, rather than levels of need. However, the needs of people living with dementia can be changeable, due to a range of factors. A dependency tool would have been useful to ensure flexible staffing to accommodate people's fluctuating needs.

We asked staff if they felt staffing levels were sufficient. They told us they were sufficient unless someone called in sick at the last minute. One staff member felt there were enough staff to address the needs of the people who used the service, but not always enough to ensure paperwork was completed in a timely manner. Another felt there were certain periods during the day when staff could be stretched, but in general levels were fine. Comments included "I would say they are sufficient. It's a busy job but I would say staffing levels have improved" and "We have busy periods, but we work well as a team and manage to get by". A relative told us, "I visit most weeks and I would say there are enough staff. They always seem to be hovering around which is good". Another said, "There always seems to be enough staff. There are always staff around, certainly during the day".

We looked around the home and found all areas to be clean, with no malodours present. Bathrooms and toilets were equipped with liquid soap and paper towels and there was relevant hand hygiene guidance. The home had undergone a recent infection control audit from the local infection prevention and control team and had scored 100% in this audit. We saw that hand hygiene audits had been undertaken on a monthly basis. Few issues were identified from these audits. A relative said, "The home always seems clean and tidy and I never really notice any smells".

We looked at health and safety information. The service had an emergency and crisis policy in place and there was a Business Continuity Plan with contact numbers. Appropriate health and safety policies and procedures were also in evidence. Maintenance records for equipment at the service were complete and up

to date. There were fire extinguishers in place on all floors and there was evidence that emergency lighting and fire alarms were tested regularly. Equipment, such as hoists and slings, was regularly serviced and maintained.

On looking around the premises we noted that some of the windows on the upper floor opened widely and did not have window restrictors in place. Although these were top windows and would be relatively difficult to get to, if someone was determined they may be able to get through them.

The provider responded to this in a timely manner and fitted window restrictors to the windows identified.

During the inspection we looked at how medication was handled. At the last inspection we found that there were issues with medicines, which meant that sometimes they may not have been given safely. At this inspection we found that medicines were being administered in a safe way.

There had been a recent pharmacy advisory visit, which had highlighted some minor issues which required action. We saw that these actions had been addressed by the service. Internal medication audits had been carried out on a monthly basis and no issues had been identified.

We looked at the MAR (Medication Administration Records) of nine people who lived at the home. These were accurately completed with no missing signatures. Each MAR also had a photograph of each individual making it easier for staff to identify the correct people when giving medicines. Any known allergies were also documented. We also checked blister packs and saw medication had been administered when signed for. This demonstrated to us people received their medication as prescribed.

We observed parts of the medication round at different intervals during the day. The home had a medication trolley on both units and we saw the medicines were locked and secure when not in use, preventing any unauthorised access. When administering medicines, staff sought people's consent first and offered people a glass of water making their medicines easier to swallow. Staff also took the time to explain what each medicine was and the reason for them taking it.

Where people required PRN (when required) medicines such as paracetamol for pain relief, clear protocols were in place about when this needed to be administered. There was also an overview of minimum/maximum dosages to be given, reasons for administration, if people were able to fully communicate and any potential side effects. This meant staff had access to sufficient information as to when these medicines were required and under what circumstances.

We found cream charts and body maps were in place when in place when creams were used. This would ensure staff knew what part of people's body creams needed to be applied to and could demonstrate they were used as prescribed. We found controlled drugs were stored securely. Staff also provided two signatures for controlled drugs when given and we checked three samples of controlled drugs and saw the stock levels tallied with the number written in the controlled drugs book. This showed us the controlled drugs could be accounted for.

Is the service effective?

Our findings

The staff files looked at demonstrated that the induction programme was robust and thorough. We spoke with four care staff who agreed that they had undertaken sufficient, appropriate training prior to commencing their employment.

Through training records and staff files we were able to see that there had been a considerable amount of training undertaken for all staff. The service had recently implemented a 'policy of the month' initiative. This entailed sending out a policy to staff each month and following up with a supervision session with questions and answers. This had proved to be very effective in ensuring staff were aware of the policies and knowledgeable about their implementation. Staff we asked about supervisions told us, "We do have them and they tend to be roughly every three months. I find them to be useful and we can talk about work and any concerns"; "I have regular supervision and they are quite consistent".

Staff we spoke with were positive about the amount and quality of training they received and told us they were able to request bespoke training if they felt it would be useful. One staff member said, "There is always loads of training to do. I've done moving and handling, safeguarding, infection control, health and safety and first aid. They seem on top of the training here". Another told us "Training is going really well and we do a lot. We always do renewals when they are due and I've been able to do my NVQ 2 and 3 as well".

We looked around the home and saw that the dementia unit had appropriate signage such as towards the lounge, bathrooms, bedrooms and toilets. Since the last inspection boards with a range of tactile objects had been added around the dementia unit for people living with dementia to utilise for extra stimulation and interest. There were memory boxes outside people's rooms, to aid orientation. The home had a small lounge, decorated in 1950s style, to aid reminiscence, a sensory room where people could relax with gentle stimulation and a hairdressing room for people to visit to have their hair done.

We asked staff members about the model of dementia care they were working to. Some were able to explain the model as being the social model, focusing on the individual and providing person-centred care. Other staff members were unsure of the model worked to, though they were able to explain how care was offered in a person-centred way.

We observed meal times in the upstairs, dementia unit and in the residential unit. We observed tables were set in advance of the meal and had condiments such as salt, pepper and appropriate cutlery. Drinks were also readily available. The menu was displayed on the wall, in picture format on the dementia unit, with people having a choice of sausage and mash or cheese and onion pie. We noted other choices and alternatives were also available to people at both breakfast and dinner time and we saw staff asking people for their preferred choice in advance of the meal.

We observed staff encouraging people to eat and they provided support as necessary. Over the lunch time period, there were four members of staff assisting people to eat and drink on the dementia unit and we saw staff were able to respond to any requests in a timely manner. On the residential unit people were more able

to manage their meals without assistance, but staff were around to respond to any requests for help. We did not see anybody being left without support. One person on the dementia unit required a pureed diet and we saw this was provided for them, with each item of food being pureed separately to provide a variety of tastes and textures. Staff told us this was prepared in the kitchen and then brought up to the unit.

We asked people if they enjoyed the food. One person said, "The food is good, I like it. There is plenty of choice. I like chicken curry". Another told us, "Food is very good and the choice is reasonable". Other comments included, "The food is nice here I must admit. There is never usually a meal I don't like"; "Food is very good really". A relative said, "[Relative] can eat himself and I'm told the food is very good".

We saw that consent forms, for issues such as the use of photographs and administration of medicines, were included within the care files. These were signed, either by the person who used the service or their representative. We also saw that staff members asked for permission before offering any intervention, for example "Is it OK if I give you your medication". One staff member told us, "I will always ask people such as if it is OK to assist with washing, dressing or oral hygiene. It is people's own choice". Another told us, "I always try to ask people what they would like to do and if they need assistance. If somebody was refusing I would try again a bit later on".

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had undertaken or were due to undertake training in MCA and DoLS. Those we spoke with demonstrated an understanding of the basic principles of the MCA and were aware of which people were subject to DoLS authorisations and why this was. They could also explain the techniques they used to address some people's desire to leave the home. One staff member said, "I've done training in the past. I feel a DoLS is required when people can't make decisions for themselves, especially regarding their safety like going out". Another told us, "DoLS is for people who lack capacity to make choices and decisions".

Appropriate paperwork referring to DoLS was kept within people's care files and the registered manager had an overview document which flagged up when DoLS applications were due for renewal.

Is the service caring?

Our findings

During our visit we spoke with four people who used the service and three relatives. One person who used the service told us, "The staff are smashing and always polite. Life is much better now". Another said, "It's a very good place, there's nothing wrong with it". Other comments included; "I've lived here for a while and am perfectly satisfied. I feel the care is good. The staff are all fine and are there for me whenever I need them I'm perfectly well treated and I find the staff to be respectful"; "We have lots of friends here".

A relative said, "It's very good. We visited quite a few homes in the area and chose here without hesitation. I like the fact the home is privately owned and has more of a family feel about it". Another commented, "We love it and have been really impressed. It's like people's own home here. It's wonderful care here and that is why there was a waiting list to get in I presume. There is always something going on". Relatives also told us, "The staff are very good, are friendly and all seem to have a very good sense of humour".

Throughout the day we observed friendly and patient interactions between staff and people who used the service. A relative told us, "Whenever we visit, [relative] is clean, well presented and looks well cared for. That is one of the reasons we like it". We spoke with staff about how they ensured people's dignity and privacy was respected. One staff member said, "If I am assisting with personal care then I will close the doors and offer people a towel when they get out of the shower". Another commented, "I would never deliver person care in front of others and make sure it is done discreetly".

We saw that people were treated with respect by staff. However, we did witness someone whose catheter tube was not properly secured and was therefore on show below their trouser leg. We spoke with the registered manager about this, as we felt it compromised the person's dignity. The registered manager agreed to address this immediately and she discussed the issue with staff.

We asked people who used the service if they were encouraged to be as independent as possible. One person said, "The staff do assist me with personal care, but do let me have a go. I like to wash my own face and brush my teeth". A staff member told us, "I will encourage people as much as possible. Even if it is just putting their own glasses on, I will let them have that independence". Another told us, "When I am supporting people to have a body wash, it might be that people want to wash their own face so I will let them".

There was a copy of the service user guide, including information about services offered, staffing structure, mealtimes, activities and the statement of purpose, in each person's room. We saw that relatives were encouraged to participate in meetings and we looked at the minutes of the most recent relatives' meeting. Issues discussed included trips out, activities and events. A relatives' satisfaction questionnaire had been sent out recently and, although only nine had been returned, the results of these were collated and comments were positive.

We saw from the care plans that people were encouraged to be involved in their care plans and reviews of care. A relative told us, "We came in yesterday for a review and are invited to meetings when they are

scheduled". Care plans included people's wishes for when they were nearing the end of their lives, if they wanted to supply this information. The registered manager told us that people nearing the end of life were supported by the staff and the local district nursing team if they wished to remain at the home. Staff had received training in end of life care.

Is the service responsive?

Our findings

We asked people if the service was responsive to their needs. A person who used the service told us, "I'm getting everything I need here and I feel the staff do as they should for me. I'm quite satisfied". Another told us, "If I ask for something they [staff] do their best". When asked about choice one person said, "The staff ask me which clothes I would like to choose from and there is always a choice at meal times".

A relative said, "I feel [relative] is getting everything he needs. If ever there is a fall or change in the medication they always keep me up to speed". Another commented, "Overall we are quite satisfied. [Relative] seems happy and is never disgruntled".

We looked at care files for eight people who used the service. These included a range of health and personal information, but were inconsistent in the level and quality of documentation maintained. We asked the registered manager about the inconsistencies within the care plans. She told us she had been working to change care plans since the last inspection, but did not start on them immediately so they were not yet finished. However, the last inspection was carried out 17 months ago, giving ample time for care plans to have been completed prior to this inspection.

Where the care records had been completed, people's preferences, such as what time they liked to get up and go to bed, whether they liked a light on at night, was recorded. We arrived early and saw that a few people were up and having a cup of tea. One person said, "I get up and go to bed when I am ready". We observed one person getting up quite late, around mid-morning, and from the conversation between them and the staff, this was their usual routine. They were offered a bacon sandwich for breakfast, which they accepted.

However, we saw that recorded choices were not always respected and, although preferences and wishes were documented in some care plans, these were not always translated into actions. For example, one person was described as liking to sit at the table for meals and enjoyed socialising with other residents. However, this person was observed sitting alone for most of the day and between 7.30 am and 9.00 am was in an arm chair away from other people whilst eating. Staff did not ask this person if they would like to sit with the others or offer any encouragement for them to be sociable.

In two of the care records, people were said to prefer a bath to a shower when asked for their preference. On looking at the personal care records we saw that only showers had been offered to them. Within one personal care record the person had clearly expressed their preference to the staff member offering a shower. The staff member had documented that the person had refused a shower as they "preferred a bath". However, there was no evidence that a bath had been offered in response to this comment. We spoke with the registered manager about this and she told us there was no reason why people could not have a bath and that the bath was currently "under used".

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

One care plan stated that the person was unable to communicate in full sentences and had difficulty storing information. The issue had been identified but no solution, for example techniques to be used for effective communication, had been documented.

Where life stories had been completed within the care files there was good information documented. However, the records were inconsistent as some people's background history, life story and personal preferences were incomplete. The registered manager said some personal information was still being completed by families.

The home arranged a number of trips out and there was a good programme of activities offered. One person said, "Yes they do make an effort with activities. I don't always join in but they are there if you want to take part". These included Zumba, chair exercises and regular visits from entertainers. There was a designated activities room, which had recently been opened up to make it more accessible to people. This had large tables, and there were arts and crafts materials and board games. Trips out included monthly "Singing for the Brain" at a church in the area, and bingo at a local bowling club.

There was a complaints procedure, which was displayed within the home and outlined within the service user guide. There had been no formal complaints made. One person said, "I have no complaints. They [staff] know their jobs". The registered manager told us some concerns had been raised regarding laundry and they were working on improving the laundry service to address this.

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

We saw that the current CQC ratings were displayed near the front door of the premises. However, the ratings were not displayed on the website.

This was a breach of Regulation 20a (2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of audits in place, such as care plan audits, medication audits, kitchen checks, hand hygiene, accident audits and monthly weight audits. These audits were complete and up to date but were not always effectively analysed and issues addressed. For example, care plans had been audited regularly, but we found gaps in care plans that had been audited and these gaps had not been addressed through the audit. We spoke with the registered manager about this and she told us her audits only documented whether senior staff had audited the plan, but did not look in depth at the records. She agreed to ensure this was done in the future.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who used the service told us, "I know who the manager is and she seems nice, always asking how I am". A relative told us, "Very approachable and seems on the ball. The manager is nice". Another said, "The dealings I have had with the manager have always been fine. Always seems to be available if needed".

We asked staff if they were happy with their jobs and the staff culture. One staff member said, "It's going great from my point of view. I love the job. There is a good culture amongst staff and we work well together". Another told us, "It's a great place to work. I get on with everybody and have no concerns working here".

We asked staff if the management at the home were approachable and supportive. One staff member told us, "I get on really well with the manager. I feel I can always talk with her and raise any issues". Another said, "The manager is good and I feel I can approach her with any issues and can talk with her on a personal level as well".

We spoke with the local authority commissioners of the service and the local safeguarding team prior to the inspection. They did not report any recent issues with the home. Healthwatch England had undertaken an 'Enter and View' inspection in September 2016. They felt the service was good overall, though reported staff's views that staffing levels could improve at times of sickness and holidays.

We saw that staff had regular one to one supervision sessions and that these had recently been themed in conjunction with the policy of the month initiative. We saw that staff had answered questions on the policies

to help enhance their knowledge and understanding. Staff told us this had been helpful and effective in adding to their knowledge base.

We looked at minutes of staff meetings, which included discussions around staff morale, staffing levels, day to day work issues, equipment and handovers. A staff member said, "The staff meetings are good. We can bring up concerns or things that are bothering us". We saw there had been a recent staff satisfaction questionnaire. The results of this were positive, with a few minor comments made, which had been addressed.

Appropriate policies and procedures were in place at the service. We saw that these had been reviewed and were up to date.

The provider and the registered manager attended relevant events and meetings, such as the local Care Home Provider Forum. This helped them keep up to date with current guidance and changes to legislation. The registered manager told us they had been invited to join a dementia research pilot programme with the local university, which was to commence in the near future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not reflect their preferences.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was failing to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The service was failing to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity