

# Indigo Care Services Limited

## Loxley Court

### Inspection report

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Date of inspection visit:  
15 May 2017

Date of publication:  
16 August 2018

### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Requires Improvement</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

Loxley Court Care Home is located on the outskirts of Sheffield. It caters for up to 76 older people whose needs may include mental health or dementia. Nursing care is provided. Accommodation is provided over three floors, accessed by a lift, which includes a challenging behaviour unit on the ground floor for up to ten people. There are three double bedrooms; the remainder of the rooms are single. Each bedroom has an en-suite toilet. There are lounges and a dining area on each floor of the home. On the day of our inspection, there were 65 people living at the home.

Loxley Court had been operating for many years. Indigo Care Services Ltd took over the home and were registered with CQC in September 2016. This is the first inspection since the new providers were registered.

There was a registered manager in place. 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.

This inspection took place on 15 May 2017 and was unannounced. This meant the people who lived at Loxley Court and the staff who worked there did not know we were coming.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Staff we spoke with were aware of how to protect vulnerable people and had safeguarding policies and procedures to guide them, which included the contact details of the local authority to report to any incidents to. However, some of the plans of care did not contain sufficient information to protect people from possible harm. We also found some staff were not following the directions given in the plans of care, for example the safe management of diabetes.

We found that there was no system for analysing these incidents and identifying trends or patterns. The registered manager was working on improvements with staff from the local authority's contracts team and the local clinical commissioning group to look at root cause analysis.

Prior to the inspection CQC had a number of notifications that staff had not had access to sufficient personal protective equipment and bedding appropriate for the level and type of care provided. The registered manager told us the budget for these was frequently overspent due to the increase in numbers of people living at the service and the complexity of their needs. However, the registered manager assured us that she always ensured there was sufficient equipment was in place.

Staffing levels were sufficient to meet people's needs. Staff had been received some training and support to provide them with the skills and knowledge to undertake their role. This included a better understanding about how to ensure that they worked within the legal requirements of the Mental Capacity Act (2005). However there was some outstanding mandatory training requirements and further work was needed to

ensure that staff understood how to support people who challenge.

The home had a happy, positive atmosphere with friendly interactions between people and staff. Staff knew people well and were able to support them in a caring way. People were supported by staff that showed compassion and empathy.

People said they liked the food and were able to choose what they ate.

Staff knew people well and people told us the staff were caring. People's privacy and dignity were respected and promoted.

A programme of activities was in place so people were provided with a range of leisure opportunities.

People said they could speak with staff if they had any worries or concerns and they would be listened to.

There were some systems in place to monitor and improve the quality of the service provided. Regular checks and audits were undertaken to make sure full and safe procedures were adhered to. However, some of these audits were ineffective as risks within the environment had not been identified and minimised.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Medicines were administered, stored and recorded appropriately. However risks related to people's health needs were not always recorded along with clear actions for staff to take in order to mitigate risks.

There was sufficient staff to meet people's needs. Staff knew people well and supported them to be independent whilst protecting them from known risks.

Staff were aware of their responsibilities in keeping people safe. People expressed no fears or concerns for their safety and told us they felt safe.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Staff had been provided with relevant training to make sure they had the right skills and knowledge for their role. However there were outstanding mandatory training requirements.

Staff were working within the requirements of the Mental Capacity Act (2005)

People were supported to maintain good health. Where staff identified a concern about a person's health, they contacted health professionals for advice and guidance.

### Is the service caring?

**Good** ●

The service was caring.

Staff were kind and compassionate to people. People were very positive about the staff.

Staff respected people's privacy and dignity and knew people's preferences well.

### Is the service responsive?

**Good** ●

The service was responsive.

People were able to express their views about how the service was run.

There were systems in place for people to complain. People said they were aware of this but had not had to complain.

**Is the service well-led?**

Not all aspects of the service were well led.

The registered manager had introduced some quality assurance systems but these had not identified issues that needed addressing.

Staff and people who used the service knew who the registered manager was and said they felt supported by them.

Staff told us the manager was supportive and communication was good within the home. Staff meetings were held.

**Requires Improvement** 

# Loxley Court

## 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 checked 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 15 May 2017 and was unannounced. The inspection team consisted of two adult care inspectors and two experts-by-experience. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of supporting and caring for older people and people living with dementia.

Before our inspection, we reviewed the information we held about the home. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. We usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted Sheffield local authority, Sheffield Clinical Commissioning Group (CCG) and Healthwatch (Sheffield). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with ten people who used the service and seven relatives to gain their views and experiences of the service, the registered manager, the cook and nine care staff. We reviewed a range of records about people's care and how the home was managed. These included care records for seven people, and other records relating to the management of the service. This included six staff training, support

and employment records, quality assurance audits, and minutes of meetings with staff. We looked at the findings from questionnaires and incident and accident reports.

# Is the service safe?

## Our findings

People who lived at the service told us "I feel safe I can lock my door when I am inside," and, "The staff are easy to talk to and they make sure I get my medicine on time."

Relatives we spoke to had mixed views about the level of safety within the home. Comments from relatives included "One benefit of [my loved one] being here - is the safety and security the staff provide for him," and "I feel so much better knowing that Mum is safe and well looked after." In contrast other comments included "I cannot settle - I cannot say that [my loved one] is safe here" and "So many things have gone wrong - we worry about [our loved one] twenty four hours a day"

We reviewed the care records that were in place in relation to the care and treatment of people in the home. We looked at risk assessments. The risk assessments covered all aspects of the person's care needs, including their dependency level, communication and senses, nutritional needs, skin integrity, mobility, overall health, mental health, mental capacity and care needs.

However we found the information contained in the care records we reviewed was inconsistent and in some cases contradictory, for example there was conflicting information in plans for people who had diabetes and the type of treatment they required to manage the condition. There were no instructions about the action staff should take if the blood glucose level was very low or very high. We looked at two people's care records and it said their blood glucose level should be checked on a weekly basis. However records we looked at showed that one person had not had their glucose levels checked since April and another person's care records we checked had not had their blood glucose levels checked throughout April. This meant people were at risk of developing serious health problems because of the unsafe management of their diabetes.

This demonstrated a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We looked at notifications received from the service and looked at care records to see how people were protected from bullying, harassment, avoidable harm and abuse that may have breached their human rights.

Prior to the inspection we had received 79 safeguarding notifications of incidents at the service between September 2016 and May 2017. It is important that people inform CQC about all accidents and incidents that may affect so that, where needed, CQC can take follow-up action.

We looked to see if accidents and incidents were reviewed, investigated, monitored and action taken to remedy the situation and to inform service improvements. We found that there was no system for analysing these incidents and identifying trends or patterns. The registered manager was working on improvements with staff from the local authority's contracts team and the local clinical commissioning group to look at root cause analysis. Root cause analysis is process that seeks to identify the causes that led to an incident happening and the actions required to prevent the incident from reoccurring.

We spoke to the registered manager about this and they acknowledged that there had been a high level of



safeguarding notifications and they felt that this was because the overall number of people living at the service had increased and a new unit which supported people with much more complex health care needs had opened.

Some of the safeguarding concerns were about incidents between people living at the service. We looked at care plans in place to guide staff in managing behaviours that challenged but they did not contain sufficient detail to enable staff to support people effectively. There was no guidance in plans of care for staff to follow in order to appropriately manage these behaviours.

Staff were recording people's behaviours in charts. These charts are called ABC (antecedent, behaviour, consequences) charts. ABC charts are designed to enable staff to understand challenging behaviour and develop suitable responses but also to inform professionals about the extent of people's behaviours. However the information lacked detail and the information was not specific enough. For example, one record stated 'when passing service user hit out and caught another service user on the cheek and then walked away.' There was no record of what happened prior to the incident or what lessons were learnt from the incident to prevent the same incident occurring again.

This demonstrated a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We found policy and procedures were in place for infection control. We saw infection control audits were undertaken which showed any issues were identified and acted upon. We looked at the standard of cleanliness in the home. We observed there were areas of the service that were malodorous. We observed that the most unpleasant odour was on the Endeavour and the Nightingale unit, the odour increased as the day progressed.

Prior to the inspection we had received concerns about the lack of personal protective equipment (gloves and aprons) pillows and duvets available at the home.

On the day of the inspection staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used the equipment when they needed to. We checked to see if there were duvets on beds and found a number of beds that had duvet covers but no duvets. We spoke to the laundry staff and they told us they had "enough duvets for everybody at the home" and 'some people choose not to have a duvet' and it's their choice."

We spoke to the care staff and they told us that 'Sometimes we run short of personal protective equipment and the registered manager has to send out for' them' and another member of staff told us "There are not enough duvets, if one gets wet we haven't got enough to change them while the other gets washed."

We spoke to the registered manager about this and they assured us that staff had access to personal protective equipment and there were sufficient duvets to meet people needs. However the registered manager told us there had been occasions when they had to send out for emergency supplies of personal protective equipment when they had run low.

The registered manager told us that the since the service had increased the number of people living at the service and the range of needs they were providing a service for the monthly budget for protective equipment, bedding and crockery was always overspent. This meant there was a risk of staff not having the necessary equipment to meet people's needs and people were at risk of receiving unsafe care and treatment.

This demonstrated a breach of Regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014: Safe care and treatment.

We looked at the arrangements for the management of medicines and found that medicines were securely stored in medication trolleys secured to the wall within the Nurses Station and Controlled Drugs within an appropriately locked cupboard within a locked room within the Nurses Station. We saw the medicine's trolley was locked between the administration of one person to another and the nurses approached people in a friendly professional manner.

We checked Medication Administration Records (MAR). Each person had a photograph of themselves to identify them on individual MAR charts, so that they were identifiable to staff. This was particularly important given the use of agency staff. We observed that when nurses administered medicines the MAR chart was signed by the administering staff member and recorded the person had been given their medicines. All staff that supported people to take their medicines had been trained to do so. We looked at nine medicines administration records (MARs) and found that most had been completed accurately.

There was a separate sheet for 'as required' medicines. This gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. There was also a similar safe protocol for topical medicines. This helped prevent errors.

Where medicines were unused or a person had refused to take them, this was identified on the MAR. We found that signatures tallied with stock levels indicating that medicines had been signed as administered and that carried forward values were always recorded.

We found some people were administered controlled medicines under the Misuse of Drugs legislation. The legislation impacts on care homes as they require special arrangements for storage, administration, records and disposal. The legislation states controlled drugs must be entered into the controlled drugs register as soon as they are received into the home. We checked six people's care records and found that this was happening.

People using the service told us "I have to take tablets - the staff make sure I get them on time" and "Oh yes - they are very good at making sure I get my tablets." One relative we spoke to told us "My [loved one] gets their medication on time and they can ask for extra pain killers during the night if they need them."

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. Staff we spoke with confirmed they had been trained in safeguarding procedures and were aware of their responsibility to protect people. Staff spoken to told us, "I have recently undertaken further safeguarding training - I now have more confidence about adult protection and safeguarding" and "I can, and do, go to any of the managers and discuss anything I am worried about"

The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service also had a copy of the local authority's safeguarding policies and procedures. This meant they had access to the local safeguarding team for advice and to report any incidents to.

We looked at the premises and whether all required safety checks had been carried out. We found that there were service record logs to confirm servicing and checks of the environment to ensure its safety, in addition to what we had seen during the inspection. These included legionella, lift, fixed electrical wiring, fire safety and gas.

We looked at the emergency business contingency plans that were available in the home, we found there were plans in place for any foreseeable emergency.

The fire alarm system had been serviced. Fire drills and tests were held regularly to ensure the equipment

was in good working order and staff knew the procedures. We looked at the personal emergency evacuation plans (PEEPs), which were in place for people who lived at the home. The purpose of PEEPs is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. We found PEEPs had been undertaken for each person living at the home so important information was available in the event of a fire.

We saw the home provided equipment to aid staff assist people safely from the building in case of emergency including evacuation chairs and an emergency sledge (used to assist people with stairs). We were assured staff had been trained in the use of the equipment as part of their fire safety training.

There was a laundry sited away from any food preparation areas. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There were hand-washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry.

We looked at the equipment that was in use to assist people who were unable to move independently, this included bath hoists and mobile hoists. We found the equipment was in a good state of repair and that it had been regularly serviced and checked by a qualified person.

We spoke with the registered manager, checked staffing rotas at the home and carried out observations throughout the day to assess whether staffing levels were adequate.

The registered manager told us they had carried out a dependency assessment on all the people who lived in the home, and they had used this to work out how many staff were required to meet people's needs safely.

People we spoke with told us there was enough staff to meet their needs and relatives agreed this was the case. Relatives we spoke to told us "There are enough staff" and "They [care staff] come quickly to her buzzer." Other comments included "They [care staff] can be stretched at times, like if two or three people need help at the same time," and "There aren't as many agency ones [care staff] as there used to be."

We reviewed the recruitment process, which was in place. We looked at the files for three recently recruited staff and found all the appropriate pre-employment checks had been carried out, including gaining a full employment history, seeking references from previous employers and a disclosure and barring service (DBS) check to ensure staff were of good character.

We saw that there was a system for checking trained nurses' details to ensure they were up to date with the Nursing and Midwifery Council. This ensured nurses were undertaking revalidation learning to remain on their professional register.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

## Is the service effective?

### Our findings

People we spoke with told us they thought staff were well trained and competent. We saw care staff carrying out care tasks competently, including turning people in bed and assisting people with limited mobility.

The registered manager showed us a staff training matrix used to check that staff received suitable and on-going training. The training matrix identified 33% of staff had completed care planning guidance, 94% dementia awareness, 29% dignity, personal care, 96% equality and diversity, 90% safeguarding, 96% Mental Capacity Act and Deprivation of Liberty Safeguards and 88% Understanding behaviour that challenges, Moving and Handling 73%. Some staff had also received training in other topics relevant to the needs of people who used the service, for example, customer care, diet and nutrition. This meant records did not support staff had received all the mandatory training relevant for their roles and responsibilities.

All the staff we spoke with told us they had completed basic training when completing their induction and some staff had undertaken further training in care of people who had dementia, nutrition and behaviours that challenge. Several staff told us they had done the challenging behaviour training but the techniques they had learnt did not fit the situation, 'Sometimes we have to react straight away.' Other members of staff also told us that they felt they would benefit from more dementia training.

Although some staff had received training to support them in their role, there was some evidence that further work was needed to ensure staff had the right skills, knowledge and experience to work alongside people who may challenge the service.

This demonstrated a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

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 authorisation 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.

The manager was aware of the role of Independent Mental Capacity Advocates (IMCAs) and how they could be contacted and the recent changes in DoLS legislation. Staff we spoke with understood the principles of the MCA and DoLS. The manager informed us where needed DoLS applications had been referred to the local authority in line with guidance and we saw records of these.

The three care plans seen held evidence of capacity assessments and best interest meetings to show full and safe procedures had been followed. They held people's signatures to evidence they had been consulted and agreed to their plan. People receiving support told us care staff asked their opinion and checked things with them.

The care plans seen all contained an initial assessment that had been carried out prior to admission. The assessments and care plans contained evidence people had been asked for their opinions and had been involved in the assessment process to make sure they could share what was important to them.

We found during the inspection that there was no shortage of food, and relatives told us "My husband has put weight on since he came to live here - that can only be a good thing" and "They have made my husband's favourite food today and made him a birthday cake" another relative told us 'The staff always offer us drinks.'

We observed breakfast was served in small rooms throughout the home, and this appeared to be relaxed as breakfast was served over a long period, as and when people chose to get up.

The catering staff were aware of people likes and dislikes - a number of alternatives were offered on an individual basis. The cook told us that they catered for a range of specialist dietary requirements. They told us they produced pureed, mashed, diabetic and soft diets if people required them and there was a specialist provider they could contact should a person require food for a specific cultural or ethnic need such as Halal. Everyone observed appeared to enjoy the food and a range of drinks were on offer throughout the day.

We also noted on the staff calm and patient were when encouraging people to the dining tables.

People were asked to choose their meal from the day's choices during the morning; however as some people were living with a diagnosis of dementia they were not able to remember what option they had chosen. Prior to the lunchtime period we saw that the menus on display did not relate in any way to the food that was served that day. During the inspection the staff corrected this with new pictorial images of the meals about to be served.

Not all menus were displayed in a 'dementia friendly' manner - it was very small print on a small blackboard - away from the areas people lived in.

The dining tables were neatly set out and looked welcoming with linen tablecloths, napkins and coasters they were also set with flowers. The staff were seen to be very calm and patient when delivering meals and asking people what they would like to eat. We observed staff offering people drinks and condiments. The mealtime was a pleasant experience.

We looked at whether people had access to healthcare services and whether this was facilitated in a timely manner. All the relatives we spoke with told us the staff looked after people properly and their relative's saw healthcare professionals when they needed to. One relative told us "They call the opticians and chiropodist - they always let me know when they do it".

Supervisions are accountable, two-way meetings that support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. These are important in order to ensure staff are adequately supported in their roles.

Discussions with staff told us supervisions were undertaken on a regular basis and that any problems or concerns they had they would talk to the manager or the deputy manager.

We asked staff about handovers. A handover is given when a new shift commences work. Staff coming on duty are given any relevant information about people's health or other needs. A handover should highlight any risks people who use the service may have. The registered manager told us they had recently implemented a new handover sheet to make sure that important information was passed.

We looked at the environment and whether it had been adapted to meet people's specific needs. We found that the environment pleasant, and there had been thought given to the needs of people who were living with dementia. The communal areas were bright and generally well decorated and dementia friendly, the bedrooms were a reasonable size and looked comfortable and generally well looked after.

There were reminiscence boxes outside people's rooms to help them recognise their own room but this was not throughout the home and there were people living with dementia on all floors.

Bathrooms and toilets had aids to assist people with their mobility to help them attend to their personal hygiene. There was an accessible garden with seating for people to use in good weather.

There was a bar and people were able to sit with their families and have a drink of alcohol or soft drink if their conditions allowed.

## Is the service caring?

### Our findings

On the day of the inspection there was a relaxed happy atmosphere at the home and staff had developed positive and caring relationships with people. People received care and support from staff that knew them well. Staff were kind and friendly with people, who in turn responded positively to staff.

Many positive comments were made about the staff. It was very good to see that staff got on well with people. Observations showed that staff treat people with dignity and respect. They respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas. The staff and residents looked comfortable together - there was a lot of laughter and friendly 'banter' between people. One person told us "They always knock on my door and treat me with respect."

Most relatives said that staff and the registered manager were good at listening to them and meeting their needs. Relatives and visitors were also welcomed in a caring and friendly manner. Comments from relatives included "The staff are kind, caring and compassionate," "They treat him well with respect and look after his dignity and they always knock on the door and protect his privacy and dignity."

It was clear staff had developed positive and trusting relationships with people and they demonstrated care and compassion in the way they communicated with and supported people. People were relaxed in their company. We witnessed a lot of shared laughter between people using the service and staff.

Staff were very familiar and knowledgeable about people's past life, preferences and dislikes. They engaged people in conversations and responded to people questions or queries in a polite and friendly manner. For example one person told us "I love my residents, they are well looked after we tend to every need, a few of us even come in on our days off to take residents out."

Relatives spoken with said end of life care had been discussed and comments included "It's too early to discuss 'end of life' but we have talked about (do not resuscitate) DNRs," and "Yes, we have discussed end of life care but it's not that time yet."

There were no restrictions on visiting times at the service. A relative said they felt welcome to visit at any time.

## Is the service responsive?

### Our findings

People told us, " We have some activities, singers and music but it's not really for a fellow" and "We have some good laughs when we do activities" another person told us "They pester me to join in but I can decide for myself,"

The service had recently appointed an activities co-ordinator to ensure there was a range of meaningful activities on offer. We spoke with the activities co-ordinator who told us that things had been 'somewhat lacking' with regard to 'meaningful and enjoyable activities'. They showed us they were highly committed to the activities being enjoyable and beneficial. The activities co-ordinator told us each person had an activities file which recorded peoples personal preferences and involvement in activities.

Relatives told us, " The activity lady is super, but she is limited in what she can do, there is only one activity coordinator for the whole building" and "It is not clear when activities are taking place - the big boards are just full of ideas and examples of activities - not the actual activity taking place."

We spoke to the registered manager about this and they explained they were in the process of recruiting another activity coordinator.

On the day of our inspection we observed a 'sing song' and general socialising event (on Bronte wing) and background music and general socialising in the afternoon.

Plans of care were divided into headings, for example personal care and physical well-being, diet and weight, sight hearing and communication, oral health, foot care, mobility and dexterity, history of falls, continence, medication, mental state and cognition social interests, hobbies religious and cultural needs, personal safety and risk. This meant staff should be able to provide individualised care to each person. People's care records included an individual care plan. The care plans seen contained details of people's identified needs and the actions required of staff to meet these needs. The plans contained some information on people's life history, preferences and interests so these could be supported. Health care contacts had been recorded in the plans and showed people had regular contact with relevant health care professionals. This showed people's support needs had been identified, along with the actions required of staff to meet identified needs.

The care plans seen had been signed by the person supported and/or their relative to evidence their involvement. Relatives told us they had been involved in their family member's care planning.

We looked at surveys to see if relatives were involved in care planning and the surveys indicated that no relatives are involved in care planning or reviews. However relatives told us "I am involved in [my loved ones] care plan," and "They know his likes and preferences. Yes, they know him, they are lovely whilst another relative told us "I have never been asked to contribute to a care plan".

We were not able to fully communicate with some people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the



experience of people who could not talk with us. We spent 30 minutes observing care and interactions on the ground floor. People appeared content and staff interacted and spoke with them in a patient and caring manner

There was a clear complaints, comments, compliments procedure in place. People and their relatives knew how to complain and they told us they would inform [registered manager] if they were unhappy with their care.

Relatives we spoke with told us that if they wanted to make a complaint they would see the registered manager. One relative we spoke with told us "The registered manager has made it clear that if we have any concerns we must tell her" another person told us "If ever I have a problem I would go straight to [the registered manager] I know she would sort it out" and "You can approach the manager about anything." In contrast one person told us "I have a few problems - but I have not spoken with the manager about them." We looked at a range of thank you cards the service and received and one stated "We felt like we were treated like members of the family, nothing was ever any trouble no matter what time of day or night we came to visit, there was always a welcome a cup of tea and a hug" and another card stated, "[My loved one] was taken care of with such caring and sympathy and compassion."

Throughout our inspection we saw staff support people's choices. We heard staff asking people their choices and preferences, for example, asking people what they would like to drink, where they wanted to spend time and what they wanted to do.

On the day of our visit we saw that care workers were very busy with care tasks and at times care staff were not visible on the unit caring for people living with dementia as they were dealing with care needs in people's bedrooms. During the afternoon we observed staff having more time to engage with and chat to the people living in the service

Before accepting a placement for someone an assessment of the person's needs was carried out so the manager could be sure they could provide appropriate support. This assessment formed the basis of the initial care plan.

On the day of the inspection we spoke to a very distressed relative they told us they were upset because [their loved one] had been admitted to hospital and no one had contacted them to let them know. The relative told us "All my father's clothes keep going missing - I have seen other men in his clothes - it is disrespectful" We spoke to the registered manager about these concerns and she responded immediately and addressed these concerns.

## Is the service well-led?

### Our findings

The manager was registered with 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

We found a quality assurance policy was in place and saw audits were undertaken as part of the quality assurance process. We found quality assurance procedures were in place to cover aspects of the running of the home. Records showed the manager undertook audits. Those seen included care plan, medication, health and safety and infection control audits. The manager also informed us they undertook regular 'walk arounds' to check the environment. However risks found during this inspection had not been identified by the internal audits undertaken. This meant the audits were not always effective and people's health and safety could be compromised.

The registered provider had undertaken a quality monitoring check in April 2017. This audit identified many of the issues we found at our inspection in relation to the monitoring and analysis of accidents and incidents, documentation of challenging behaviour. An action plan had been put in place to address these shortfalls. However, we found issues on our inspection in the same areas of the service that showed a failure to address and improve service delivery to ensure a safe high quality service.

This demonstrated a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

People using the service and relatives knew who the registered manager and senior staff were. One person told us "The office is not bad now you can talk to them," "Yes, it's well managed" and We can talk to [the registered manager] about anything - they really goes out of their way to make us feel reassured."

Other comments from relatives included "[the registered manager] is easy to talk to and would listen and try to make changes," "It's under control and interactive" and "It's a happy and friendly place and I would recommend it."

People, their relatives, visitors and staff were actively encouraged by the registered manager and other senior staff to be involved in developing the service.

People we spoke with told us they were encouraged to speak out at meetings and fill out surveys with help. Relatives said they "thought they were listened to." Resident meetings were held and there were minutes with actions and outcomes. For example, people had commented on the smell of carpets in one

particular area. This carpet had been replaced and further improvements to the area were planned in the coming months.

We looked at minutes dated 21 April 2016, 11 August 2016 and 15 February 2017. Relatives had requested that the meetings be every three months. Dates of the meetings held indicated this had not been happening. The home had policies and procedures in place that covered aspects of the service.

The policies seen had been reviewed and were up to date. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training and induction programme. This meant staff could be kept fully up to date with current legislation and guidance.

The manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. The manager confirmed any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed this.

The registered manager statement of purpose that they had shared with people living in the home. A copy of the statement of purpose was available in the main reception area. It clearly described the type of home and the services they provided.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>There was a risk of staff not having the necessary equipment to meet people's needs and therefore people were at risk of receiving unsafe care and treatment.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider had undertaken a quality monitoring check in April 2017. This audit identified many of the issues we found at our inspection in relation to the monitoring and analysis of accidents and incidents, and documentation of challenging behaviour. An action plan had been put in place to address these shortfalls. However, we found issues on our inspection in the same areas of the service that showed a failure to address and improve service delivery to ensure a safe high quality service.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>Although some staff had received training to support them in their role, there was some</p>

evidence that further work was needed to ensure staff had the right skills, knowledge and experience to work alongside people who may display behaviour that challenges.