Care Quality Commission

Loxley Health Care Limited

Loxley Court

Inspection report

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Sheffield, S4 8NB
Tel: 0114 242 0068

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Ratings

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

Overall summary

We carried out this inspection on 20 July 2015 and it was an unannounced inspection. This means the provider did not know we were going to carry out the inspection. At the last full inspection carried out in November 2014, we found the home to be non-compliant with the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; 10; Assessing and monitoring the quality of service provision, 13; Management of medicines, 18; Consent to care and treatment and 22; Staffing. Compliance actions were given for regulations 13, 18 and 22 and a warning notice was issued against regulation 10. We followed up on these breaches during this inspection.

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 ensuite toilet. There are lounges and a dining area on each floor of the home. On the day of our inspection, there were 38 people living at the home, some living with dementia and one new admission.

Summary of findings

It is a condition of registration with the Care Quality Commission that the home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the home is run. The registered manager was present on the day of our inspection.

People and their relatives told us they felt the home was safe, effective, caring, responsive and well led. Comments included; "[The home] is a safe place to be", "[Staff] always ask me what I want doing and how they should do it", "People are so kind, I never thought I'd be this happy in a home but it's great" and "I go to residents meetings when I can. It's a good time to tell [staff] what we think about the home. And it's a good place to chat."

People were protected from abuse and the home followed adequate and effective safeguarding procedures. Care records contained personalised and relevant information for staff to assist in providing personalised care and support.

Staff told us they felt well supported and they received regular supervisions. Training updates were provided regularly and training targets were measured on a 'red, amber, green' scale, where red meant that training or updates were required and green meant training had been completed. Where staff wanted to attend any other training courses, they were able to request this as part of their supervisions.

We found good practice in relation to decision making processes at the home, in line with the Mental Capacity code of practice, the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The registered manager carried out regular audits at the home and recorded any required actions on audits and on the 'home action plan'. Actions that had been identified as a result of audits were verified and signed off by the registered manager when they had been addressed and completed.

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?
The home was safe.

People had their freedom supported and respected and were protected from bullying, harassment, avoidable harm and abuse. Regular risk assessments were carried out to ensure people's safety.

There were enough suitably qualified, skilled and experienced staff on each shift at the home, including nurses who administered medicines to people safely and appropriately.

Good

Is the service effective?
The home was effective.

Staff had the knowledge and skills they needed to effectively carry out their roles and responsibilities. Some staff had requested additional training to assist them in providing care and support to people with complex needs.

People were asked for their consent before any care, treatment and/or support was provided.

People were provided with sufficient food and drink to ensure they maintained a well-balanced diet and had access to relevant healthcare professionals, where required.

Good

Is the service caring?
The home was caring.

People who lived at the home and staff had developed positive, caring relationships. People were able to express their views to staff and they were actively involved, along with their relatives where possible, in making decisions about their care and support.

The privacy and dignity of people who lived at the home was respected and promoted.

Good

Is the service responsive?
The home was responsive.

Care plans of people who lived at the home were responsive to their needs and had been written with the involvement of people, their relatives and other relevant healthcare professionals. Care records contained details of people's preferences, likes and dislikes.

Complaints were adequately addressed, investigated and responded to. People and staff told us they felt able to complain or raise any concerns with the registered manager.

Good

Is the service well-led?
The home was well-led.

The home promoted a positive culture that was person-centred, open, inclusive and empowering. There was an emphasis on support, fairness and transparency at the home, from staff of all levels. People felt able to be themselves and speak with staff or the registered manager, if required. Regular meetings were held for staff, people who lived at the home and family and friends.

Good

Summary of findings

The registered manager provided good management and leadership at the home. Regular audits were carried out and robust records were maintained to assist with the delivery of high quality care.

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 was 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 home under the Care Act 2014.

This inspection took place on 20 July 2015 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection was carried out by two adult social care inspectors and two experts-by-experience (ExE's). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, we contacted 11 stakeholders including local NHS teams and Clinical Commissioning Groups (CCG), the local authority care home support team, a podiatry service and a tissue viability nurse. Stakeholders we spoke with told us they had no current concerns about Loxley Court in the main, but that there were areas in which the home could improve. We also checked any previous notifications or concerns we had received about the home. This information was used so that we could check issues or concerns had been dealt with appropriately.

During our inspection we spoke with four people who lived at the home and three of their relatives to obtain their views of the support provided. We spoke with ten members of staff, which included the registered manager, the administrator, care workers, an activity worker and ancillary staff such as catering and domestic staff. We also spoke with three health professionals who were visiting the home during our inspection.

We looked at documents kept by the home including the care records of four people who lived at the home and the personnel records of seven staff members. We also looked at records relating to the management and monitoring of the home, including any audits carried out and reviews of care documents and policies.

Good

Is the service safe?

Our findings

People told us they felt safe at the home, knew what it meant to 'stay safe' and felt there were enough staff to meet their needs. Comments made by people who lived at the home included; "I'm safe here. [Staff] make sure of that" and "There was a time not far back when there weren't enough staff – and they were really pulled out - but there seem to be more staff around now." One relative of someone who lived at the home told us; "If you have any concerns, you can talk to any of the staff here and they'll help you out."

Everyone who lived at the home that we spoke with told us they received their medicines how they liked and when they were required.

During our last inspection on 11 November 2014 we found evidence of a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 12(1) including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. The provider sent us an action plan, identifying actions to be taken and timescales for completion, in order for them to become compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, which took place on 20 July 2015, we found the management of medicines at the home had improved and the home was following written policies and procedures, which were up to date and relevant.

We looked in people's care records at care plans relating to medicines. We found each care record contained care plans that detailed the medicine name, dose, frequency and method of administration. Information was present on how people liked to receive their medicines and guidance for staff to follow. For example, in one medicines care plan we read that the person took their medicines orally but that they sometimes spit their medicines out. Guidance for staff stated that staff should supervise the person taking their medicines to ensure they were swallowed. This demonstrated staff were provided with clear instructions on how to administer medicines safely and in a way that people preferred.

Medication Administration Records (MAR) were well maintained, signed by the administering member of staff when the medicine had been administered and contained no gaps. We carried out a stock check of nine medicines across the units at the home and found these were correct, according to the MAR's. We checked the stock levels of five controlled drugs at the home and found these were correct, according to the controlled drugs register. Controlled drugs are prescription medicines, which are controlled under the Misuse of Drugs legislation. Temperature checks of the treatment rooms, where medicines were stored, and medicines refrigerators were carried out on a daily basis. We saw temperature checks of the refrigerator had identified a problem with the temperature, which sometimes exceeded the maximum temperature for storage of certain medicines. This had been addressed and a new refrigerator had been ordered to ensure storage temperatures were adequate. There had also previously been an issue with high temperatures in one of the treatment rooms. This had been addressed and a fan had been installed to lower and maintain the room temperature. No unlicensed (over-the-counter) medicines were administered by staff at the home. This meant the home ensured medicines were managed so that people received them safely.

During our last inspection on 11 November 2014 we found evidence of a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. The provider sent us an action plan, identifying actions to be taken and timescales for completion, in order for them to become compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, which took place on 20 July 2015, we found staffing levels at the home had increased and there were now sufficient numbers of permanent staff available on each shift.

We checked staffing rota's at the home and carried out observations throughout the day to assess whether staffing levels were adequate. We found there were enough staff members on each shift with the right mix of skills, competencies, qualifications, knowledge and experience. We saw a nurse was provided on each floor of the home. Staff worked well as a team and received support from each other when needed. Staffing levels were regularly assessed according to the needs of people who lived at the home. On the day of our inspection, staffing levels throughout the home consisted of the registered manager and deputy manager (who was supernumerary), three

Good

Is the service safe?

nurses, fourteen care assistants, a laundry worker, three domestic assistants (one per floor), two kitchen workers, two maintenance workers, a receptionist and an administrator. Staff were appropriately deployed throughout the home. Agency staff were sometimes used by the home but this was being reduced as more permanent members of staff were being recruited. This meant there were enough staff on duty to adequately meet people's needs.

Care records we looked at demonstrated people were protected from bullying, harassment, avoidable harm and abuse that may have breached their human rights. Care records contained regularly reviewed assessments and care plans, that had been carried out with the involvement of the person and/or their relatives and that had been updated when required or if the needs of the person had changed. Relevant professionals had been involved in the reviews of care plans where required and appropriate. Risk assessments and care plans contained details of how to keep the person protected from discrimination in areas including age, disability, gender and belief. They also contained details of people's needs in areas such as; behaviour, psychological and emotional needs, communication, mobility, nutrition, continence, skin, breathing, medicines, hygiene and social support. Care records also contained 'personal evacuation plans', with information of how to assist each person during an emergency or untoward event. This demonstrated the home had measures in place for dealing with emergencies and there were appropriate assessments and plans to protect people from bullying, harassment, avoidable harm and abuse.

Staff we spoke with told us about the different types of abuse, signs to look out for and how they would report any concerns, both within the organisation and externally. Staff also told us there were formal and informal methods of sharing information on risks to people's care and treatment. We saw handover sheets were completed, which contained information about how every person who lived at the home was and any concerns that staff on the next shift needed to be aware of. This meant staff knew about abuse, how to report any concerns and that there were formal and informal methods used to share information on risks to people's care and support.

The safeguarding log held at the home contained information of any safeguarding concerns and alerts that had been raised. We saw these concerns and alerts had been investigated by the home and outcomes recorded. The local authority safeguarding team confirmed that the home made appropriate referrals. Safeguarding investigations had been carried out with relevant and appropriate individuals, including other healthcare professionals. Any actions identified as a result of safeguarding investigations were recorded and we saw each concern or alert had been signed and dated when an outcome was reached and the concern or alert had been resolved. Safeguarding policies and procedures were up to date and relevant. This meant the home followed safeguarding policies and procedures, adequately investigated safeguarding concerns and put appropriate actions in place to ensure, as much as possible, that people's safety was maintained.

We looked at the adverse events log kept at the home, which contained details of any accidents of incidents. At the front of the adverse events log, we saw a summary sheet that detailed the date of the event, brief details of what had happened, actions required and a signature and date, when actions had been completed. Individual adverse event form had been completed for each event and contained details of the likelihood of recurrence, the impact of the event, the level of investigation required, actions taken, who had been informed, a conclusion and details of who needed to be notified, for example, the Care Quality Commission or the Police. We saw that the home took appropriate action regarding adverse events and each adverse event form had been signed and dated when complete and actions had been put in place to reduce the risk of the event occurring again. This demonstrated the home had arrangements in place to deal with and continually review adverse events in order to identify themes and take necessary action to reduce the risk of accidents and incidents occurring again.

We looked at the staff personnel files of seven staff members who worked at the home and found adequate pre-employment checks had been carried out by the registered provider. These checks included photographic identification, proof of address and right to work in the United Kingdom, (at least) two reference checks from previous employers to confirm their satisfactory conduct and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable

Good

Is the service safe?

groups, by disclosing information about any previous convictions a person may have. This meant the home followed safe recruitment practices to ensure the safety of people who lived at the home.

Good

Is the service effective?

Our findings

People told us they received their care in the way they wanted it and that they were given choices about their care and support. One person told us; "[Staff] make sure they do things the way I want. If I ask for something doing a certain way, that's the way they do it." One person who had Parkinson's Disease told us that, although staff provided care and support in the way they wanted, they also felt staff should have more knowledge of their medical condition. They told us; "There are one or two staff who have Parkinson's Disease in their family and they understand, but I think other staff need more understanding and awareness, as well as training – it's not just about tremors – there's much more going on with me."

People who lived at the home and their relatives told us they felt the food provided at the home was good. They also told us they were able to choose what they ate. One person said; "We choose what we want from off of the menu. If we don't want what is on the menu, we can just ask for what we want and the kitchen [staff] make it for us."

During our last inspection on 11 November 2014 we found evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. The provider sent us an action plan, identifying actions to be taken and timescales for completion, in order for them to become compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, which took place on 20 July 2015, we found the home was acting in line with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found the home to be acting within MCA 2005 legislation and observed people being asked for consent before any care and support was provided. In care records we looked at, there were details about the person's mental capacity, which was reviewed on a regular basis to ensure they were still relevant, particularly if the person had fluctuating capacity to make decisions. For example, in one care record we saw that a mental capacity assessment had been carried out for the person, which demonstrated the person lacked capacity to make decisions about their care and treatment. Another mental capacity assessment demonstrated the person lacked capacity to manage their finances. We saw that, following these assessments, best interest meetings had been held with relevant healthcare professionals, including a GP and a nurse, and the person's family. Best interest meetings are held to ensure that any decisions made about the care, treatment and support of a person are done so in their best interests. We saw that the persons wife had had input into these meetings, as their advocate and the person who had lasting power of attorney. An advocate is a person who speaks or writes on someone's behalf when they are unable to do so for themselves. A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or make decisions on their behalf. There are two types of LPA's; 'health and welfare' and 'property and financial affairs'. People who were deprived of their liberty had appropriate DoLS authorisations in place or had DoLS applications submitted to the local authority for authorisation. Staff we spoke with were able to explain the main principles behind the MCA 2005 and DoLS and what this meant for people who lived at the home. This demonstrated the home acted in line with the MCA 2005 and DoLS.

We checked staff personnel files to see if staff had received adequate induction at the beginning of their employment at the home and ongoing training. We found staff had completed an appropriate induction on commencement of their employment at the home, which included mandatory training areas. We spoke with one person who lived at the home, who told us they felt they would benefit if staff were to receive additional training in some complex medical conditions, such as Parkinson's Disease. We looked at the training matrix held by the home and saw that staff received regular training updates in most areas including safeguarding, moving and handling, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This demonstrated staff were up to date with their mandatory training requirements.

Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or

training requirements. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. We looked at the staff supervision and appraisal matrix kept by the registered manager. We saw that the staff supervision matrix showed that most staff had received supervision, in line with the home's policy and staff who had not received supervision within the last two months had dates identified for when their supervision was due. We saw on the staff appraisal matrix that staff had received an annual appraisal or that a date had been identified for this to be carried out. We saw evidence of staff requesting additional training as part of their appraisals, including training on Parkinson's Disease, dementia and mental health.

We asked staff if they felt adequately supported by the registered manager. All staff we spoke with confirmed that they did. Staff comments included; "Yes, the manager does support me and it's good to work here" and "The manager now is the best one I've worked with, she's approachable and friendly but she does what she has to do." This demonstrated staff were adequately supported to identify areas for improvements, concerns, training requirements and to effectively carry out their roles and responsibilities and that they felt the manager was approachable.

In care records we looked at, we saw nutritional assessments were completed to assess whether the person was at risk of becoming nutritionally compromised and that these were reviewed with appropriate frequency. Care records we looked at demonstrated people were encouraged to maintain a well-balanced diet that promoted healthy eating and gave the person choice over what foods and drinks they consumed. Assessments had been completed to identify any support that the person required when eating their meals. For example, in one care record we looked at, we read that the person was on a thick pureed diet that needed to be calorific and fortified. This record also stated that the person required assistance from staff to eat, using a small spoon, following advice from a Speech and Language Therapist (SALT). In some people's bedrooms, we saw yellow "swallowing status" posters above some beds where people were receiving care in bed, which gave detailed information from the SALT team on an individual's diet and fluid care.

We observed lunchtime in three of the dining rooms at the home. We found mealtimes were not rushed and the dining areas were bright, airy and well-decorated for people. We saw that care assistants knew the food preferences of people who lived at the home. Several people asked for, and were provided with a different meal to the one they initially requested. This was done with helpful conversations with the person to establish what they wanted to eat. We saw care assistants promoting people's independence by offering assistance with mobility appropriate to their needs. Some domestic members of staff were employed as support staff during meal times, which allowed for more staff time to help with the meal experience. One staff member said about this; "It adds variety to the day and it means we get to know the residents better." We saw that the food waste tubs on floor 2 were placed outside the dining room so residents were not close to the food disposal process. This demonstrated people had a good dining experience and were supported to have sufficient to eat and drink to maintain a balanced diet.

We saw people and their relatives were involved in regular reviews to monitor their health. Where required, referrals were made to, and assistance sought from appropriate healthcare professionals. We saw care records contained details of any visiting healthcare professionals that the person had seen and details of each visit. This demonstrated the home supported people to maintain good health and have access to relevant healthcare services.

Bedrooms were well decorated and most were personalised. We saw bedrooms were bright, airy, clean and fresh-smelling. Televisions were present and some people had photographs, pictures, music systems and CD's. We saw one bedroom with shelves and display units filled with models of classic cars that the person collected. We saw other bedrooms that had no decoration or personal possessions at all, including some bedrooms of people who spent most of their time there. Some bedrooms looked very stark as there were no decorations and were painted in a cream colour. These bedrooms would benefit from some attractive, personalised decorations for people to enjoy or additional colours adding to rooms to make them more pleasing to the eye.

Good

Is the service caring?

Our findings

We asked people who lived at the home and their relatives how they felt about staff at the home. Everyone we spoke with told us they felt care staff were kind and attentive. Comments made by people who lived at the home included; "The carers here are such lovely people. They've always got time for you and they're so friendly" and "The carers are very patient. Sometimes I struggle to get my words out, but they always wait until I've finished. They give me time to say what I need to say. And also, they always answer any questions I've got." Another person who lived at the home, who had limited communication gave a 'thumbs up' and smiled broadly when we asked about care staff.

One relative of a person who lived at the home told us; "The staff here are just brilliant. They do a marvellous job with [family member] and I couldn't wish for better care for her." Another relative said; "I know the carers come in regularly to check on [family member] and turn her. I've got no worries there."

Throughout the day, we carried out observations and saw that people were treated with kindness and compassion. People who lived at the home were clean and well groomed. All the gentleman who lived at the home were clean shaven and the women had their hair done. The activities person at the home told us people often chose to have health and beauty treatments as part of their activities, such as hand massages and manicures. During our observations, we did not see any staff member discussing people's care and support needs openly, or within ear shot of others. When personal care was provided, bedroom and bathroom doors were shut to ensure the person had their privacy and dignity maintained. This demonstrated staff were respectful of people's privacy and dignity.

We looked in care records and found that people and their families had been involved in making decisions about their care and support, where appropriate and possible. For example, in one care record, when looking at activities and past times of the person, we read; "[Person] enjoys walking about with other clients on the unit, can also benefit from trips outside so he can walk about and view a good and nice environment." We also saw care records contained details of people's past lives, to assist with providing personalised care. For example, in one care record we read; "[Person] worked on the railway all his life. Liked working with steam engines" and in another care record, we saw; "[Person] has worked in different jobs, these include working with silver where different designs for Canada and Middle East [were made]. He said this was his best job and [he] enjoyed it." In another person's care file, we read; "[Person] also collects cars as he is interested in old cars. His first memory of liking cars was going to a local garage and someone had left an old British car on the banking and he used to go and look at it." We looked in this person's bedroom and saw many model cars that the person had collected and decorated their bedroom with. We spoke with several staff about people who lived at the home and staff were able to tell us about people's lives, likes, dislikes and preferences. This demonstrated the home made information available for staff get to know people better and to provide a personalised and person-centred approach to care and support.

We asked the registered manager if any information regarding advocacy services was provided to people at the home. The registered manager told us that, although this information is not provided as a matter of routine, it would be provided to people when required.

The registered manager, staff, people who lived at the home and visiting relatives told us there were no restrictions on visiting times at the home.

A 'Do Not Attempt Cardio Pulmonary Resuscitation' form (DNACPR) is used if cardiac or respiratory arrest is an expected part of the dying process and where CPR would not be successful. Making and recording an advance decision not to attempt CPR will help to ensure that the patient dies in a dignified and peaceful manner. In care records we looked at, where required and appropriate, DNACPR forms were in place, where either an advanced decision had been made by a person who lived at the home when they had capacity or by a relevant healthcare professional, if the person lacked capacity to make this decision. DNACPR forms contained information about the person's condition and reasons why CPR would not be attempted. These forms also contained dates the forms were completed and reviewed and had signatures of relevant professionals who had been involved in the decision, including a GP and a nurse from the home. Care records contained details of any funeral arrangements, where people and/or their families had been willing to

Good

Is the service caring?

speak about this. This meant the home had arrangements in place to ensure the body of a person who had died was cared for and treated in a sensitive way, respecting people's preferences.

Good

Is the service responsive?

Our findings

People told us they felt the home and staff were responsive to their needs. They told us that staff gave them choices about what they wanted to wear and they were able to choose what times they went to bed and got up in the morning. One person told us; "I normally get up early, but today I felt tired, so I had a lie in."

People who lived at the home told us they were able to maintain good social relationships with others. Comments included; "We [people who lived at the home] chat a lot to each other and we're good friends" and "You couldn't stop us talking if you tried, we all get on."

We asked people who lived at the home about activities that were available for them. One person told us; "We do a few activities. We do little exercises and watch DVD's. We go out sometimes if there are enough staff." We saw some people's bedrooms were personalised, with items of significance or interest to the person present. For example, in one bedroom, we saw many shelves and display cabinets for the person's large collection of model classic cars. One relative told us; "I've been told I can bring things in from home for the walls, but [family member] doesn't notice much around her, so I've not done it. Anyway, I have a struggle to get here just myself. I've purchased some equipment for [family member], such as a TV, a CD player and a fan, so she's comfortable in here."

People we spoke with had no need to make a complaint but told us that, if they did need to, they knew how to do this.

Care records we looked at contained personalised information and were written with the involvement of people who lived at the home and their families, where possible. There was information about the persons past life, interests, favourite activities and preferences. This meant staff had access to information to provide personalised care and support for people.

We spoke with the activities co-ordinator at the home and carried out observations of activities on the day of our inspection. We saw limited activities on the day. The activities co-ordinator told us that this was due to there only being one activities co-ordinator on shift that day, due to annual leave. On the day of our inspection, the activities co-ordinator carried out activities with people on a one to one basis, providing manicures, massages and social interaction. We looked in care records and found that people regularly took part in activities. Activities that had previously taken place and been attended by people who lived at the home including making Easter bonnets, watching films, reading reminiscence books, pamper sessions, sensory activities (to assist people who have experienced changes in their sensory capacity) and a game using a parachute, to encourage gentle exercise and improve fine motor skills. We also saw evidence in care records of people going out into the local community to parks and recreational areas. This demonstrated activities were made available and people were supported to take part in activities, build and maintain relationships and avoid social isolation.

We looked at the complaints and compliments file held at the home and found that concerns and complaints were addressed, investigated and responded to in a timely manner. At the front of the complaints log, we found there was a summary sheet with brief details of complaints, dates of investigations carried out and the outcome of these investigations. Signatures were present to demonstrate who had completed these actions. This demonstrated the home listened to complaints and effectively investigated and reached a satisfactory outcome.

People who lived at the home, their families and friends and staff members all told us the registered manager was approachable. They told us the registered manager always had their office door open when they were available to speak with. This demonstrated the registered manager made themselves available for people to speak with to raise any concerns, complaints, compliments or to give any feedback.

Good

Is the service well-led?

Our findings

People told us they felt able to speak with the registered manager and that they were involved in decisions about the home. One person who lived at the home said; "The [registered] manager is lovely. Easy to talk to. I wouldn't hesitate speaking with her."

When we asked staff what would make the home a better place, comments included; "More residents, as long as we get more staff too" and "More chance to get some of the residents out."

During our last inspection on 11 November 2014 we found evidence of a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014] and we issued a warning notice. The provider sent us an action plan, identifying actions to be taken and timescales for completion, in order for them to become compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, which took place on 20 July 2015, we found the home had improved their governance and monitoring of the home and had effective systems in place to monitor the quality of service provision.

Audits carried out at the home were done so regularly and included audits of care records, quality assurance, medicines, mattresses, laundry and cleaning. We saw that, where actions had been identified from audits, these were recorded and signed when completed. For example, on the medicines audits, we found an action had been recorded to replace a refrigerator in the treatment room, where medicines were stored, as temperatures were not adequately low to safely store some medicines. We spoke with the registered manager about this and a nurse at the home, who confirmed that a new refrigerator had been ordered. This demonstrated regular audits took place at the home and, where issues or actions were identified, these were addressed and resolved.

There were regular staff meetings held at the home including 'head of department' meetings, 'health and safety committee' meetings and meetings for domestic staff members and qualified staff members. We also saw that general staff meetings were held on a regular basis and were used as an arena to discuss any concerns, provide feedback and raise any issues about the service provided. There were also regular meetings held for people who lived at the home, their relatives and/or visitors. This meant the home ensured regular meetings were held to measure and review the satisfaction of people and staff regarding the home and the delivery of care and support.

We looked at the 'home action plan' and saw that actions identified as a result of audits, staff meetings, relative meetings and meetings for people who lived at the home were recorded. We saw each entry on the home action plan had details of the date the action was originally added to the plan, actions required, who was required to complete the actions, a target date for completion, outcomes, progress and a completion date. These were all checked and verified by the registered manager. This demonstrated that, where actions had been identified, they were addressed and a detailed record was kept.

We carried out observations throughout the day and spoke with the registered manager and found that the attitudes, values and behaviours of staff were kept under constant review. The registered manager carried out regular supervisions, where the values and behaviours of staff were discussed. The registered manager also carried out a daily walk-around of the service to keep under constant review the values and behaviours of staff.

It is a condition of registration with the Care Quality Commission (CQC) that the home have a registered manager in place. The registered manager was present on the day of our inspection and had been in post since January 2015.

We looked at the business continuity plan kept at the service, which was reviewed and updated on a regular basis. This included details of possible emergencies or incidents that could cause disruption to the service provided, such as a disruption to the electricity supply, fire and flood. Information was recorded on the control measures that would be put in place and any actions to be taken in case of an emergency. There were details recorded of the home's 'sister homes', where people who lived at the home would be able to go if Loxley Court was not suitable to remain in. Details of local supermarkets, emergency telephone numbers, a local place of safety, key contacts, next of kin details and a list of taxi companies were also recorded. The home had emergency evacuation plans in place for each person who lived at the home, with details of

Good

Is the service well-led?

how to safely evacuate each person, should this be required. This demonstrated the home had procedures for dealing with emergencies and had a robust business continuity plan in place.