Silverline Care Limited

Manorcroft

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The last inspection took place on 26 January 2018 and we found the service required improvement at this time. Following the last inspection, we met with the provider to ask the provider to complete an action plan to show what they would do and by when to improve the key questions to at least good. At this inspection we were assured improvements had been made to people's safe care and treatment, person-centred care, recruitment processes and staff training. We found some improvements had been made to how people consented to care and treatment but found the home still required improvement in this area. We found some improvements had been made to how the home was managed but found the home still required improvement in this area.

Manorcroft is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Manorcroft is registered to provide accommodation, personal care and nursing care for up to 40 people. There were 37 people living at the home on both days of our inspection. Manorcroft is a large two storey purpose built building offering accommodation across two floors accessed by a passenger lift. Each floor has a communal lounge and bathrooms. Outside there is a garden and patio area with seating.

The home had a registered manager who was available throughout our inspection. 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.

People told us they felt very safe living at Manorcroft and their relatives felt assured their family member was safe. Staff had received safeguarding training and knew how to identify and report suspected abuse and knew the procedure to report any incidents.

Staff received training and support required to meet people's needs. Recruitment procedures were robust to ensure suitable staff worked in the home. People were cared for, or supported by, sufficient numbers of staff.

Standardised risk assessments were used in care plans so risks to people's health and safety could be effectively tracked and monitored.

Medicines were administered safely and with due consideration to national guidance.

The registered manager had audit systems in place, including for monitoring accidents and incidents, although not all checks were documented thoroughly, for example, the registered manager told us they undertook a daily walkround of the home but there was no documentation to support this.

Care plans contained personal histories and people's preferences in relation to their physical needs. People were offered choice and their care plans contained some mental capacity assessments. Consideration had been given to people's consent, and some consideration given to people's capacity to do so for some aspects of care and support needs. Applications to lawfully deprive people of their liberty (DoLS) had been appropriately submitted to the local authority and were well managed. However we found some instances were people had not had their individual rights upheld.

Training was available and took place although some people had not been trained there were plans in place to do so. Staff supervisions and appraisals were taking place however these had not been undertaken in line with the registered provider's policy.

People were provided with a good choice of freshly prepared food and snacks and drinks were available throughout the day.

People were supported to receive access to healthcare which was demonstrated and recorded in care plans.

People were consulted and had been involved in the refurbishment of the home, choosing colours and items for both communal areas and their own bedrooms.

Staff were aware of the need to ensure people's dignity and their privacy. Staff were aware to support people's independence wherever possible.

The registered provider's monthly quality reports showed oversight of the service. The registered manager followed and completed these systems. Senior staff within the home were responsible for completing audits and reviews of care files however there was no evidence of manager oversight of these because we found many of the system alerts had not been actioned.

Feedback was sought to engage people, relatives and staff in the running of the service.

People and their relatives felt they were well looked after at Manorcroft. People enjoyed different activities and staff engagement and interactions with people was kind, caring and dignified.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were identified, however not all documentation had been completed.

Medicines management was robust and in line with national guidelines.

Staffing levels were sufficient and recruitment procedures were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

People were offered good choice throughout their care and support however some of the care plans we looked at did not always consider people's mental capacity to consent to certain aspects of their daily lives.

Staff were knowledgeable and had completed appropriate training however opportunities to attend supervisions and appraisals was sporadic.

People's nutritional needs were met and people had access to attended regular healthcare appointments.

Is the service caring?

Good

The service was caring.

People valued their relationships with staff and people felt very well cared for.

People were treated with kindness, dignity and respect. Staff respected people's privacy.

Staff promoted and encouraged people's choice and independence.

Is the service responsive?

Good

The service was responsive.

Information about people's care needs was person-centred and generally detailed.

There was a wide opportunity for people to be involved in a range of activities throughout the home and in the local community.

People and their relatives knew how to complain and were confident the manager would address their concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager was very supportive and well-respected by people, relatives and staff.

The provider had systems in place to monitor the quality of the service and regular audits were carried out. These were not always effective.

People, their relatives and staff had a voice in the running of the home with different opportunities to contribute. The manager was responsive to these comments.

Manorcroft

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 21 and 24 September 2018 and was unannounced on the first day and announced on the second. The inspection team comprised one adult social care inspector, one bank inspector and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On the second day an adult social care inspector visited. On both days of the inspection there were 37 people living at Manorcroft.

Before our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. We contacted commissioners of the service, safeguarding and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spoke with sixteen people who lived at the home and eleven of their relatives or friends. We spoke with the registered manager, the acting regional manager, one senior careworker, two care assistants, an activities co-ordinator and the cook. We looked around the building and saw the communal lounges, dining rooms and bathrooms. People showed us their bedroom, which had recently been refurbished. We spent time observing care in the communal lounges and dining areas to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records, which included three people's care files in detail. We also inspected four

staff members' recruitment and supervision documents, staff training records and other records relating to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection the service was rated inadequate in this area. This is because the management of fire safety was unsatisfactory, the administration of medicines was unsafe and the provider had not taken appropriate steps to employ fit and proper persons. At this inspection we found improvements in all these areas.

People told us they felt very safe living at Manorcroft. People's comments included, "I certainly do feel safe here," "I can lock my door every time I leave, that keeps all my things nice and secure," "One thing about living here it offers you great security" and "I feel so much more confident than when I was at home."

Relatives told us, "Safety comes first here - as a family we so appreciate that", "The staff go to great lengths to help mum keep safe", "Isn't it funny? I never even give her safety a thought, we have every confidence in the staff here", and "I can absolutely say this is a safe place."

Staff were knowledgeable about safeguarding procedures. Staff we spoke with were able to describe what to do to protect people from harm and confirmed they received regular safeguarding training. One staff member said, "I am included in all the training programmes. I feel confident about reporting any concerns to the management." Another told us, "The managers put safety first, they make sure staff and residents alike are kept as safe as possible."

Accurate detailed information was available to support emergency evacuations. Simulated fire evacuations were planned but had not taken place however fire drills took place regularly. Staff confirmed they had taken part in fire drills and knew what to do in the event of a fire or other emergency. They said people all had personal emergency evacuation plans (PEEPs), these were in people's care plans and in an emergency file near the entrance to the home. We did not see these in two of the care plans we looked at. We brought this to the attention of the registered manager who arranged for these to be completed.

Staff knew what actions to take to reduce the risk of falls. We discussed a person who had repeated falls and staff had moved the person's furniture to reduce hazards and the person was supported on a one to one basis at night.

People's care plans included standardised risk assessments and were scheduled for reviews on a monthly basis however the home did not always assess risks in a timely way. Two of the care plans we looked at did not have comprehensive risk assessments completed. For example, one person had been admitted to the home with a pre-admission assessment showing a pressure ulcer but an assessment for the risk of pressure ulcers (Waterlow assessment) and a skin check had not been completed. Daily progress notes did record this person had a pressure relief cushion in place and was being supported to change position regularly.

Another person's care plan showed they were at high risk of falls and had an eating and drinking risk but the person's Malnutrition Universal Screening Tool (MUST) had not been completed.

Another person had been admitted to the home eight days before we visited. A skin check had been carried out and a red area of skin noted. Care plans stated the person had a falls risk of 11 and a nutrition risk of 12. We asked staff what these numbers meant as no guidance was available in the care file. A senior carer said, "We have asked for guidance, a social worker has asked the same question but we don't know." Staff said the malnutrition universal scoring tool (MUST) should have been completed to determine malnutrition risk but had not. The care plan stated the person had a risk of dehydration and a fluid record had been maintained.

People were supported to eat enough to maintain a balanced diet. A person with an assessed risk of malnutrition had been referred to a dietician who had prescribed nutritional supplements. A detailed care plan was in place. The person had been weighed each week and after gaining weight, had recently been discharged from the dietician.

Staff discussed the care they put in place when people were at risk of malnutrition. They said the food was good and snacks were always available and offered to people if they were at risk of not eating meals.

People and staff told us there were enough staff to support people safely. A person said, "There always seems to be enough staff, you don't have to wait long for help". Another person said, "If the staff get too busy they can take a while to come." Some care staff commented there were not always enough staff because unexpected sickness and absence was not always covered, however they all believed there were always enough staff to care for people safely. Staff said they were sometimes rushed, one staff member said, "People get safe care but might have to wait; buzzers can take too long to answer."

The inspection team all observed call bell response times lengthening during the period after lunch on the first day of our inspection. There was no facility for the registered manager to monitor call bell times. We brought this to the registered manager's attention who told us they would consider reviewing staff rotas during this period. The registered manager told us staffing levels at the home were monitored monthly and the explained how they reviewed people's dependency needs on a monthly basis to support this. There was no documentary evidence to support this and we discussed with the registered manager how this may be improved.

Staff were recruited safely. We looked at the employment files of two recently employed staff and two existing staff members and saw they contained an application form, interview questions and answers, two references and proof of identity, which included a photograph of that person. We saw that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff.

Staff said they had received training to care for people who might have behaviour that challenged. When a person had become agitated we saw records followed best practise recommendations to record antecedents, behaviour, interventions and outcome.

Staff confirmed they had been trained to use equipment, including hoists. One said they had recently taken a hoist out of service to be repaired as the manual failsafe was not working. They said people who needed to use a hoist had been assessed so the correct size sling was used. We saw from care plan documentation that this was the case.

The registered manager had plans to develop staff 'champions' in key areas such as safeguarding, moving

and handling, nutrition and falls prevention. These staff would receive additional training and support colleagues in best practices in these areas.

Staff said slings were always allocated for single person use and not shared. This helps reduce the risk of cross infection. Staff could all discuss their role in preventing cross infection citing handwashing as the most effective method. Staff knew when they should wash their hands and use personal protective equipment such as gloves and aprons.

A relative said, "The domestic team are great, they keep this place looking lovely." We saw the kitchens were clean and well maintained. A notice outside prohibited entry to people not wearing a white coat and directed people to use alcohol hand-gel to disinfect their hands before entering. A cleaning schedule was in place and followed with daily, weekly and monthly tasks being signed as completed. A dedicated handwashing sink was equipped with hand-wash soap dispenser and paper towels.

A person told us, "I get my medication on time - and I can have extra painkillers during the night if I need them." Medication was administered safely by trained and competent staff. Medication was given in response according to people's needs and preferences, for example if a person was asleep or did not feel like taking their medicine at that time, staff noted and returned at a more convenient time for that person.

The medicines trolley was kept locked and medicines were accounted for. Procedures for the delivery, storage and removal of medicines no longer required were robust and well-organised. People's medicines were kept in a locked cabinet in their rooms and room temperatures were checked and recorded at each administration of medicines. There was a fridge in the treatment room for storage of medicines which needed to be kept refrigerated.

One person's care file listed their medications and allergies. Their care plan had been updated following a recent visit from a respiratory specialist nurse and stated rescue medication needed ordering, including antibiotics and steroids, as per the advice given. However, a person admitted two days before our visit did not have their medications listed, or an assessment of needs or a care plan although they were receiving medicines via a syringe driver. We discussed this with the registered manager who arranged for this to be completed.

A senior carer who administered medicines said they had received training from. and been shadowed by, a pharmacist before being assessed as competent. They said competency checks were made by the manager about every six months. They knew what to do if they identified a medication error, completing an incident form and recording details on the reverse of the medication administration record (MAR). They said the manager carried out a 'Perfect Ward' audit (this was an electronic audit system which looked at all the different aspects of the care plans and records) and gave feedback to staff about how medicines were administered. We saw from documentation these were completed each month.

The registered manager explained how they welcomed feedback from visits and inspections and used these to learn and improve the service. The registered manager and the regional manager had recently identified a need for more clinical support within the home. They had written a business plan, had presented this to the registered provider and had been allocated additional funding to improve staffing in this area. There were further plans to improve the home.

Analysis of accidents and incidents took place regularly each month, although the information captured was limited. The registered manager had identified from these audits a person who was experiencing high numbers of falls and had used this information to gain additional funding to support this person during the

hours of their high falls. This had increased the person's wellbeing.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we rated the service 'Requires Improvement' in this area. This is because we found care plans did not always contain appropriate and person specific mental capacity assessments. At this inspection we found people had received mental capacity assessments and these were documented in their care plans however staff did not always understand how to ensure risks were balanced with people's capacity to consent to their support and independence.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Manorcroft had assessed people's capacity and made appropriate referrals to the local authority for DoLS authorisation.

People's electronic records contained capacity assessments and best interest decisions for various aspects of their care and treatment. For example, support with personal care, taking of photographs and support with mobility. During the inspection we observed staff provided people with choices, for example, what to eat, what activities to take part in, and where to sit in the lounge area. People were always asked for their consent by staff before support was provided. Staff allowed people to refuse their support. For example, one person did not want to take their medication and had capacity to choose to do this. Staff gently encouraged them and returned and asked again before respecting this person's wishes. This meant people were supported by staff to make their own decisions.

People and relatives were complimentary about the food. One person said, "Let me tell you. I have put weight on since I have been here, surely that's a good thing." Other comments included "If you let the staff know they will cook you anything", "The food is traditional and home cooked", "The food is good and you always get a choice," and "The staff know what I like to eat." A relative told us, ""I regularly have a meal here the food is very good and there is always a good choice."

People told us they could have cooked food for breakfast if they wanted it. People were able to choose when to eat their food and staff ensure food was served hot at the time the person wanted it. The staff were seen and heard discussing the menus for the day with people and had a list of people's choices as the meal was delivered. If people did not prefer the food on offer people were give alternative choices.

Most people chose to eat in their rooms. The dining tables (on the ground floor) were set with a linen tablecloth as two people arrived to sit at the table. Condiments weren't available however salt and vinegar was available from the hot trolley from which the food was served and people were asked if they wanted these before they received their meal. The catering assistant served all the food from a heated food trolley and food wasn't served to people until they were ready to eat it or could be assisted to eat. This meant

people received fresh, hot meals.

Staff were very calm and patient when delivering and serving food; they ensured people were sat or positioned correctly and were comfortable to eat their meal. Staff were responsive to people's needs and offered people hot and cold drinks throughout meal times. The meal time experiences were calm and friendly.

Most people chose to stay in their rooms, this was documented in their care plans. When people wished to move to communal areas this was accommodated. People were asked about where they wanted to sit and what they wanted to do at all times. Staff said they always asked people for their consent before delivering personal care and said people were asked to sign written consent to photography and bedrails, however we found people were not always asked to consent to care and treatment plans.

The registered manager showed how they recorded DoLS applications and authorisations. This demonstrated applications to lawfully deprive people of their liberty had been submitted to the local authority appropriately.

A person had been assessed as having mental capacity to make their own decisions, one of these included the risks of continuing to take part in an activity which could be harmful to their health. A risk assessment had been carried out and a care plan was in place stating, '[Person's name] has full capacity and is aware of the significant risks.' Staff were directed to, 'ensure [person's name] is allowed access to [the potential health risk] day and night.' No DoLS was in place however daily records stated staff had frequently refused to allow the person to take part in this activity. On one occasion when the person said they wanted to take part in the activity a care worker had written 'I explained that if [they] leave the premises I would have to contact the police and inform the manager.' Other entries read 'explained 9pm is the cut off time for going out', '…threatening to leave the building', 'attempted to leave… explained [person's name] cannot go outside.' When we asked a care worker if the person was free to leave the building, they said, "[Person's name] can go out whenever (they) want to. We tell (them) the risks and might try to persuade them to stay." We discussed this with the registered manager. On the second day of our inspection the registered manager told us they would review this person's care plan to ensure they were supported to engage in this activity whenever they wished to do so.

Although this same person had given written consent to photography and closing their bedroom door they had not been asked to sign consent to their care plan. A recent review had involved printing care plans and giving them to the person's daughter and staff had recorded the relative was happy with the contents. They also stated '[person's name] is fully involved with all aspects of care and is also happy… no current concerns.' However, behaviour charts had been used to record the person's anxiety and distress when they had been prevented from leaving the building for a cigarette.

A person who had recently arrived to live at the home had not been given the opportunity to discuss their care plan with staff and was unhappy about a motion sensor placed in their bedroom. We spoke with the person, who had mental capacity to make their own decisions, and they were unhappy about the alarm. It was designed to make a loud noise to alert staff if the person stood up next to their bed but also alarmed when staff of visitors stood there. The person felt this was very restrictive and they had not been asked if they agreed to the use of the technology. We brought this to the attention of the registered manager who told us they would review this person's care plan.

We were not assured staff always understood the distinction between keeping people safe and allowing them to make their own decisions when they had mental capacity to do so. Of the three staff we spoke with,

two remembered receiving training and said they understood the MCA was about people's abilities to make decisions and DoLS restricted people's liberty when they lacked capacity. The third did not remember receiving training (we checked and found they had received training) but knew people had a DoLS in place when doors were locked and they were restricted from leaving. We brought this to the attention of the registered manager who said they would review staff's understanding of the Mental Capacity Act.
This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's rights have not been upheld.

During the last inspection we also found staff training did not equip staff with the knowledge and skills to support people safely. At this inspection we found staff had received appropriate training to support people safely. A staff member said, ""I am pleased that the organisation offer me training and support with regard to my work. I am so much more aware of the difficulties people suffer from with dementia." Another staff member explained how they had been supported to attend a leadership course and how they worked with colleagues in other care homes within the organisation. They were passionate about how this had benefited them and how they could share their knowledge with colleagues in the home.

The induction records we looked at for new staff showed not all had received health and safety induction training prior to them starting work at the home. The registered manager told us this was due to the absence of the maintenance staff and had plans in place to ensure this was completed. There were also plans in place to train an additional member of staff to provide this induction training if the maintenance staff was absent in the future.

The care and treatment people received was good and people who lived at the home praised the standards of care provided by staff. People told us, "The staff really know what they are doing, they know just how to look after me", "My breathing apparatus is checked regularly. The staff call the hospital if they have any queries about my care", and "I have every confidence in them [staff] when they are taking care of me."

All the people spoken with said they were supported by a range of health care professionals, such as GPs, speech and language therapists, opticians, chiropodists and dentists. A person told us, "They are so good at making my appointments for the chiropodist and the optician." Relatives commented, "If mum needs to see the specialist they [staff] take care of everything" and "The staff team have seen to all mum's dental needs since she lost her dentures, that's more than I could do."

Handovers took place with all staff at the start of each shift. This meant staff were knowledgeable about people and had up-to-date information about their care and support needs. Staff told us they always read people's profiles and care plans when they had time and we found from observations and talking to staff they knew people well. For example, all of the staff we spoke with were able to describe the ways they supported people to prevent pressure ulcers using equipment and changing position to relieve pressure.

Daily handover sheets had been identified by the registered manager as needing improvement. These improvements would ensure new regulations about data protection were being met as well as providing more information to staff about each person living at the home. Change to these was planned for the beginning of October. Staff said they received a handover at the start of each shift with key information about all the people living in the home and especially changes. They said senior staff communicated verbally with them if there were changes throughout the day.

Signage throughout the home was supportive of people living with dementia. Corridors throughout the home were bright, had easily identifiable handrails and were decorated with pictures. A relative told us, "Everywhere in the home is so much better. There has been a lot of decorating." People had been involved

in choosing wallpapers and colours for their rooms, each bedroom was individual and personalised with people's own items. People had been provided with 'mood boards' to participate and contribute to the refurbishment of the communal lounges.

Good

Is the service caring?

Our findings

At the last inspection we rated the service as being good in this area. People and relatives made positive comments about the staff. People's comments included "The staff are kindness itself," "I am so well looked after here," "The staff cannot do enough for you," and "I cannot fault the care offered to me." Relatives said, "The staff brighten my mum's day", "You must understand, I have no doubt that the care here is first class", "My friend loves the staff, they have become her new family", and "As a family we are warmly welcomed by the staff every time we come."

Observations showed staff treated everyone with dignity and respect. The interaction between staff and people demonstrated a genuine warmth and mutual respect. There was good humour and appropriate use of touch in all interactions between people and staff.

Staff 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 and there was a lot of laughter and friendly 'banter' between people. People said that staff were good at listening to them and meeting their needs. Relatives and visitors were also welcomed in a caring and friendly manner.

Staff showed a good understanding of people's specific communication needs, for example, one person did not speak English and staff used signs, symbols and pictures to communicate with them. A relative said, "Although mum has problems with communication there is always a smile of her face when the staff come to care for her."

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. People's communication needs were assessed and information provided to people in a suitable format such as large font.

A person told us, "The whole staff team respect my religious beliefs and practices, they do all they can to arrange group meetings here or take me to a service," another person explained, "A group of young people come to re-enact bible stories and create discussions, it's fascinating, I love it." Another person said, ""I feel that I can declare my beliefs in the presence of anyone, there is no oppression here."

Meeting people's spiritual, religious and cultural needs was a focus of the team. The staff supported people with whatever spirituality means to the individual. Outside 'religious' groups from more than one religious denomination regularly visited and supported and responded to specific requests. There were good links with the local church ensuring people can attend a variety of events as and when they chose to do so.

Good

Is the service responsive?

Our findings

At the last inspection we rated the service as requiring improvement in this area. This is because we did not feel people were consistently receiving person-centred care to meet their individual needs. We found this had improved at this inspection. People's comments about the activities they enjoyed included "I cannot tell you the range of activities we do, the list is endless, we are spoilt for choice", "[Activities co-ordinators] always make sure we are happy with the plan of activities, I love going out on trips", "[Activities co-ordinators] often allocate dedicated time with me alone, we get to have a good reminisce about the old days, I really appreciate it," and, "We have spent so much time outside this summer, we even had an outside church service, it was wonderful."

Relatives' comments included, "[Activities co-ordinators] understand our mother. What can I say? They have helped her confidence build since she came to live here," "My husband communicates more during the brilliant activities than at an any other time," "[Person's name] has a good choice of activities to choose from," "The quality of the events and activities seem to suit everyone," and "Never a day goes by where there isn't a good choice of activities on offer."

The home employs two dedicated activities co-ordinators. We spoke with them and they displayed a full understanding of the physical and psychological benefits of activities on people's wellbeing. The activity co-ordinators held regular meetings with residents and relatives to discuss their needs and preferences. People were seen and heard planning the day's activities with the activity co-ordinator. Two people had requested some 'one to one' time the previous day and we observed this taking place as planned.

People were seen to laughing and enjoying a reminiscence session. One person was encouraged to talk about their family being involved in the licensing trade. This person looked confident and delighted to be sharing their experiences and created an active discussion in the group. This provided a format for people to engage, and participate, in lively discussion and debate reinforcing a positive community in the home.

We also observed members of the housekeeping team actively engaging with people, taking some time to chat with people.

People were encouraged to maintain relationships with family and friends and staff were knowledgeable about these. A relative said "The managers have made sure that staff meet our needs as a whole family."

The home used an electronic record system to record people's needs. Staff used a hand-held device to record daily information about people. This meant all staff had immediate access to people's records and there was no delay in this information being shared. The system highlighted when monthly reviews were due. During the second day of our inspection we found some of these reviews had not yet been completed.

People had their needs assessed before moving into the home which included risks to people's safety. A pre-assessment was undertaken and details were recorded about all aspects of people's life and their needs. Staff said people's social history was recorded, and we saw in one person's care plan these details included

their previous occupation, family members, hobbies, pets, food the person liked and particularly detailed information about the clothes the person liked to wear. However two other care files did not include this personal information. We raised this with the registered manager who arranged for these to be completed.

People and their relatives knew how to complain and were confident to do so. People's comments included, "I could speak with any member of staff if I had a problem, [name of staff member] is my go to person if I have any problems", "I always speak my mind and would say if anything was wrong", "[Name of manager] is great, she is always checking out with you that things are alright, I could tell her anything," and "If I had a problem I would go straight to [name of manager] she is so easy to talk to."

We spoke with one relative who told us, "I must say someone from the management team said that they would discuss the closure of a complaint with mum. We have heard nothing since." People's daily records showed staff having the confidence and taking responsibility to deal with minor concerns themselves. We discussed with the registered manager how these could be recorded in the complaints log. The registered manager told us they would consider options to put this in place.

Where people had chosen to discuss their end of life wishes these were well-documented and detailed. A person said, "All my end of life thoughts and actions are documented; they're good that way."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the service required improvement in this area. We found concerns with the efficient of audits at the home as we did not feel the systems or processes always operated effectively.

At this inspection we found improvements had been made however some of the systems had not always identified when risk assessments and care plan reviews had not been completed. In addition the registered manager had failed to identify where people's individual rights had not been upheld, however during the second day of our inspection the registered manager confirmed they had taken action to ensure people's rights were upheld; including the right for people to make unwise decisions.

The registered manager used a quality audit timetable to undertake audits concerned with all aspects of the management of the home. These included care documentation, medication, nutrition, environment, person experience, skin integrity, infection control, health and safety, catering, safeguarding, finance and admissions. We saw these had been completed as planned however had failed to identify areas which needed clarification. For example, it was not clear. how often or whether a mattress and bed rail audit had been undertaken or how often or when shower heads had been cleaned.

The registered manager used a training matrix to track which staff had attended training and when training needed to be reviewed, however this had not identified discrepancies in health and safety induction training for new staff.

The electronic care plan system enabled the manager to have oversight of when and what care plan reviews were needed. We found these had not been identified by the registered manager and so appropriate action had not been taken.

The electronic care plan system enabled the manager to have oversight of pre-admission assessments and subsequent risk assessments from people's care and support needs. We found the audit system had not always identified when these had not been completed.

People's comments about the management of the home included, "I know the manager well, she comes to see me often", "The manager definitely knows what she's doing", and "I trust this manager". Relatives told us, "You can go to the new manager about anything, she will sort it out" and "Seriously, [person's name] is the best manager that has ever been here..."

The registered manager explained how they had regular 'get togethers' for people and their relatives where they discussed the running of the home and then had a pie and pea support or a cheese and wine evening. The registered manager said these had been well attended and the informal nature of the events encouraged people to talk to her at any time. Relatives agreed, commenting, "I am regularly invited to the 'relatives meetings'", "[Name of manager] is constantly asking us what we think about the service", "Following the meetings the managers take our ideas on board", "If I have any issues [name of manager] will sort them out", and "You can talk to [name of manager] about anything."

We saw from meeting minutes that actions on suggestions were taken. One person told us, "I have lived here a number of years, I can tell you that things are now improving, when the managers say they will do something they do." One relative said, "The managers make you feel valued and involved, I no longer feel like a nuisance when I raise concerns, and we see action."

Staff were equally positive about the management of the home with comments including, "Having been here many years this is the best management team we have ever had and the residents come first", "This is a great place to work I couldn't be more supported", and "I absolutely love my job I get all the support I need." Staff told us they attended ad hoc staff meetings and were given information, an opportunity to talk and discuss things, and could raise concerns or issues. We saw from meeting minutes staff were actively involved in these meetings.

The registered manager told us about the improvements they had made since starting in the post. The registered manager had recently participated in writing a report to the board to source additional funding for two new members of staff; this had been agreed.

The registered manager was able to actively track improvements and developments within the home. A capital expenditure plan showed identified actions and how these would be funded and the home had recently undertaken refurbishment throughout the home with further works planned.

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 11 HSCA RA Regulations 2014 Need for consent People's rights were not always upheld. People's rights to make unwise choices were not always considered. People's independence was not always supported.