Red Rocks Nursing Home Ltd

Red Rocks Nursing Home

Inspection report

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Ratings

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

Overall summary

Red Rocks Nursing Home is registered to provide support for up to 24 people with nursing and personal care needs. It has 23 bedrooms one of which is large enough to be shared. There are communal toilets and communal bathrooms with specialised bathing facilities for people to use and all bedrooms have private washing facilities.

There was a registered manager in post who participated in the inspection visit. 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'.

During this inspection, we found breaches of Regulations 11, 12, 17 and 18 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 this report.

We looked at the care files belonging to four people who lived at the home. We found they did not adequately

Summary of findings

cover all of their needs and risks. Some risk assessments and care plans failed to provide adequate or clear information to guide staff in safe and appropriate care and some care plans and risk assessments were generic. This meant that people's plan of care was not always personalised to their needs and preferences. Staff lacked sufficient guidance therefore on how to provide people with person centred care and manage their risks. We also found that the risk management advice given by other healthcare professionals in relation to one person's care had been changed without professional clarification being sought beforehand. This placed the person at potential risk of harm. During the inspection, professional advice was gained and the change agreed.

We found that where people had mental health conditions which may have impacted on their ability to consent to decisions about their care, their capacity had not been assessed in accordance with the Mental Capacity Act 2005. In addition, although deprivation of liberty safeguard applications (DoLS) had been made to the Local Authority they had not been based on capacity assessments in line with MCA 2005, which meant that individuals were at risk of being inappropriately deprived of their liberty. We found that the manager and staff we spoke with lacked a clear understanding this legislation designed to protect people's human rights. This placed people at risk of being unlawfully deprived of their liberty and their legal right to consent to their care.

We observed a medication round and saw that the way in which medication was administered was not always done in accordance with the provider's safe administration procedure. This placed people at potential risk. Some prescribed creams were stored un-securely in people's bedrooms and during the medication round we observed that some medication was put into the palm of the staff member's hand before putting it was put into person mouth using their fingers. After the inspection, the provider informed us that professional advice had been sought and it had been agreed that this was the best method to use to ensure these people took their medication.

We observed the serving of lunch and saw that there was a choice of suitable nutritious food and drink. People we spoke with were happy with the food and choices on offer. People identified at risk of malnutrition received a fortified diet to promote their nutritional intake and were involved with professional dietary services where this was appropriate.

Staff employed were subject to pre-employment and criminal record checks to ensure they were suitable to work with vulnerable people. The number of staff on duty was sufficient to meet people's needs. Staff responded promptly to people's care needs and the delivery of care was unrushed and compassionate.

Staff training records showed the majority of staff had completed the provider's mandatory training programme but had not received sufficient training in dementia, mental capacity or the deprivation of liberty safeguards. We found that this training gap impacted significantly on the implementation of this legislation at the home.

Staff we spoke with felt confident and supported in their job roles but the staff records we reviewed did not provide evidence that all clinical staff had received regular supervision in their job role or had their performance and development needs routinely reviewed. There was also no clinical lead nurse in relation to the supervision of nurses in the workplace.

We observed staff supporting people at the home and saw that they were warm, patient and caring in all interactions with people. Staff supported people sensitively with gentle prompting and encouragement and people were relaxed and comfortable in the company of staff. From our observations it was clear that staff knew people well and genuinely cared for them. People looked well cared for and people who lived at the home and their relatives were positive about the staff at the home and the care they received. The provider employed an activities co-ordinator who offered a range of activities to occupy and interest people. On the day of our visit, we saw that people enjoyed craft and group activities.

During our visit, we saw some elements of good person centred practice. There were several incidences where people's needs were responded to by staff in a way that connected with the individual they were supporting. The culture of the home was positive and inclusive and visitors were made welcome by all staff. Staff worked well

Summary of findings

together and all the staff we spoke with told us they had a good relationship with each other and the manager. The manager interacted with people pleasantly and the atmosphere at the home was relaxed and homely.

The home was clean and well maintained. The home was tastefully decorated and people's rooms were light, spacious and airy. Whilst the service is not a specialist in dementia care, the home cared for some people who lived with dementia. We found that the home's décor and signage required some improvement to ensure that people who lived with dementia and other mental health issues were able to remain as independent as possible. Records in respect of the safety of the premises showed that the home's systems and equipment were regularly serviced and inspected to ensure they were fit for purpose.

People who lived at the home, relatives and other healthcare professionals were able to express their feedback through satisfaction questionnaire which was sent out regularly. The surveys returned so far in 2016 indicated that all respondents were satisfied and very happy with the care provided.

There were audits in place to check the quality and safety of the service but some were ineffective. We found that the manager and the staff team failed to adhere to some of the provider's policies in order to ensure safe and appropriate care and some legislation in relation to people's care was not understood or properly implemented at the home. For example, mental capacity and deprivation of liberty legislation. This indicated that the home's management and leadership required improvement.

At the end of our visit, we discussed some of the issues we had found with the manager and the two nurses and two administrators that the manager invited to this feedback discussion. We found that they were receptive and open to our feedback and demonstrated a positive commitment to continuous improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People we spoke with felt safe at the home. Staff we spoke with knew how to identify and respond to potential abuse.

Risks in relation to people's care had not always been properly assessed and risk management advice had not always been followed. People's emergency evacuation information was poor.

Staff were recruited safely and the number of staff on duty was sufficient to meet people's needs in a timely manner.

The storage of some medication required improvement but people had received the medications they needed.

Is the service effective?

Requires improvement

The service was not always effective.

The Mental Capacity Act 2005 had not been followed to ensure people's consent was legally obtained. The manager lacked adequate knowledge to implement this legislation effectively at the home.

Staff had received some of the training required to do their job role effectively but lacked training in mental capacity. Some staff had not received an appropriate appraisal or supervision in their job role.

People were given enough to eat and drink but records in relation to nutritional needs and risks required improvement.

Is the service caring?

Good

The service was caring.

Everyone we spoke with spoke highly of the staff at the home and the care they received.

Staff were kind and respectful when people required support. A warm compassionate approach was observed in all interactions.

People's independence was promoted and people were able to make choices in how they lived their lives.

Staff were familiar with people's needs and spoke warmly about the people they cared for.

Is the service responsive?

Good

The service was responsive

Summary of findings

Care plans and risk assessments were not person centred and required improvement Staff had a good knowledge of people's needs however and we saw some good examples of person centred interactions.

A range of social activities was provided and visits from the local church were arranged to support people's religious needs.

Referrals to other healthcare professionals were made as and when required in support of people's health.

There was a complaints procedure in place. People and relatives we spoke with knew how to make a complaint but said they had no complaints.

Is the service well-led?

Requires improvement

The management and leadership of the service required improvement.

There were some quality assurance systems in place to monitor the quality of the service but they did not effectively identify all of the risks to people's health, safety and welfare.

Policies and procedures and mental capacity legislation had not always been followed by the staff team. This placed people at risk.

People's satisfaction with the service was sought through satisfaction questionnaires. Feedback was positive.

The culture of the home was open and inclusive. The manager and staff showed a positive commitment to continuous improvement.

Red Rocks Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 23 and 24 March 2016. The first day of the inspection was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with five people who lived at the home, three relatives, the provider who was also the registered manager, the care administrator, three nurses, two health care assistants, the office administrator and the cook. We looked at a variety of records including four care records, three staff records, staff training records, a range of policies and procedures, medication administration records and a range of audits.

We looked at the communal areas that people shared in the home and a sample of people's individual bedrooms. We observed staff practice throughout our visits.

Requires improvement

Is the service safe?

Our findings

People we spoke with said they felt safe at the home and had no worries or concerns.

Some of people's needs and risks in the delivery of care where in place for example, moving and handling, skin integrity, nutrition and their level of dependency. We found however that people's risk assessments and care plans lacked adequate details of people's individual needs and the care they required. For example, some care plans and risk assessments were not individualised and some risk management actions were generic. We also found that some risks in relation people's care had not been assessed at all. This meant staff lacked guidance on how to prevent this risk from occurring. This placed people at risk of inappropriate or unsafe care.

For example, four people whose care files we looked at indicated that they had bed rails in place to prevent them from falling out of bed. None of the files we looked at contained a risk assessment relating to the use of bed rails in respect of each person's individual care. This meant the risks associated with the use of bed rails had not been assessed appropriately. We asked the manager about this and they acknowledged that no risk assessments had been undertaken. The Health and Safety Executive provides specific guidance on the use of bed rails and the importance of ensuring a thorough risk assessment is undertaken prior to and at regularly intervals throughout their use to ensure they remain a safe and viable option for the person concerned.

One person had swallowing difficulties that placed them at risk of choking and aspiration pneumonia. Aspiration pneumonia occurs when a foreign body, such as a small piece of food goes 'down the wrong way' causing a chest infection to develop. We found that neither of these risks were adequately assessed and managed. Staff had no guidance on the signs and symptoms to spot in the event of a choke or aspiration incident for example, coughing, difficulty breathing or, guidance on what to do should an incident occur.

One person had a medical condition that placed them at risk of seizures. The risk of a seizure, the signs and symptoms to spot and the action to take both during and after a seizure had not been assessed. This meant staff had no suitable guidance how to prevent and support the person if and when a seizure occurred.

We also found that where risks had been identified and professional advice obtained, this advice had not always been followed. For example, one person's hospital discharge notes and a letter from their medical consultant showed that risks in relation to the person's nutritional needs were to be managed by the provision of a special soft diet. During the first day of our inspection, we observed two incidences where the person was fed a diet contrary to this advice. When we asked the manager about this, they told us the person's relative had requested the person be given a 'normal diet' and they had acted upon this request.

We asked the manager if they had checked with the person's medical consultant or the hospital team that this change in diet was safe and appropriate. The manager acknowledged no professional medical advice had been sought. This meant that the manager and staff at the home did not know whether the diet provided on the request of the person's relative was safe for the person to eat. During the inspection, professional advice was gained by the manager to show that the person was able to have the diet being provided by the home.

We found a lack of personal emergency evacuation plans (PEEPS) for people who lived at the home. PEEPS provide emergency service personnel with summary information about a person's needs and risks during an emergency situation such as a fire. This information assists emergency service personnel to quickly identify those most at risk and the best method by which to secure their safe evacuation. We asked the provider about this. They provided us with some emergency evacuation information from the fire risk assessment file but this information was insufficient, inaccurate and out of date.

Accidents and incidents were recorded on accident and incident forms and we saw that appropriate action was taken to access suitable support for people involved in accidents and incidents. We observed two incidences however where inappropriate moving and handling techniques were used to support people with mobility issues. This placed people at risk of an accident or injury. We spoke to the nurses on duty about this. They acknowledged that staff knew these techniques were inappropriate.

Requires improvement

Is the service safe?

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that identified risks in relation to people's care were adequately managed.

There was evidence to show regular health and safety tests were carried out on the premises and the equipment in use at the home. The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected and serviced by external contractors who were competent to do so. This ensured the premises and its equipment remained safe and suitable for its intended purpose.

The kitchen was awarded a five star food hygiene rating from Environmental Health in August 2015. This meant food hygiene standards were rated as "very good". We visited the kitchen and found that some kitchen cupboards and drawers were unclean. We asked the cook about the cleaning schedules in place. They told us that there were no set times for cleaning the kitchen, that the kitchen was cleaned after every meal but that many jobs, such as cleaning the cupboards were done 'as and when'. This meant there was no adequate system in place to prevent the build-up of dirt and bacteria in all areas of the kitchen.

The rest of the home was visibly clean with no offensive odours. Two people we spoke with told us, "Everything is spotless" and "The room is immaculate. They clean every day". We saw that people's rooms were light, airy and spacious. There were cleaning schedules in place to monitor the cleanliness and cleaning activities in each person's bedroom and communal areas.

We saw that there were adequate supplies of personal and protective equipment such as aprons, gloves and anti-bacterial hand gels available in the home to promote good infection control standards. A recent audit by the NHS Infection Control Team showed that the home received an overall score of 90% with some minor improvements required. The manager had documented the action they had already taken in response to the audit and a current programme of refurbishment was underway to take account of any remaining areas.

People's needs were responded to promptly by staff, calls bells were answered promptly and there was a constant staff presence in communal areas to ensure people had access to support. We looked at staff rotas and talked to both the manager and care administrator about staffing levels. We found that staffing levels were sufficient and were monitored in accordance with people's changing needs. People we spoke with at the home told us "There are plenty of nurses on duty" and "The staff are always around".

We looked at the personnel records for three members of staff and saw they were recruited safely. Pre-employment checks were undertaken which included the verification of the person's identity, previous employer references and a criminal record check. The professional registration of nursing staff was also checked with the Nursing and Midwifery Council prior to appointment.

We looked at the arrangements for the safe keeping and administration of medicines at the home. The majority of prescribed medications were stored appropriately but some prescribed creams were stored un-securely in people's bedrooms. This meant this medication was accessible to unauthorised staff, visitors and other people who lived at the home. We drew this to the attention of the nursing staff.

We checked a sample of people's medication administration records. We found that people's medication records were accurate and their stock of medication balanced with what had been administered. This indicated that people had received the medication they required.

We observed a medication round. The nurse was polite and kind to people during the administration of medication and the whole process was unrushed and person centred. Gentle but positive encouragement was given to people who struggled to take their medication or who were forgetful during the administration process. The nurse was observed to put some people's medication into the palm of their own hand, prior to, putting into the person's mouth with their fingers. This is not good practice as it increases the risk of the medication becoming contaminated and unsuitable for use. We spoke to the nurse about this who acknowledged that this was not best practice. After the inspection the provider informed us that professional advice had been sought and it had been confirmed that this was the best method to use to enable these people to take their medication.

Some people's care plans indicated that they had 'as and when' required medication for the management of pain. People's care plans stated that a formal assessment of

Requires improvement

Is the service safe?

people's pain levels was in use. We found no evidence this was the case. When we asked a nurse about this, they were unable to find any assessment records in place to demonstrate that the people whose care files we looked at had these in place. This meant people's pain levels may not have been assessed to ensure adequate pain relief was administered.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. Although the policy had been reviewed in December 2015, it failed to clearly specify the legal duty placed on staff to report any incidents of a safeguarding nature to the Care Quality Commission and the Local Safeguarding Team at the Local Authority without delay.

We spoke with two members of staff about safeguarding vulnerable adults from potential abuse. Both staff demonstrated an understanding of potential types of abuse and the action to take should abuse be suspected. They both said they had received safeguarding training from the provider and staff training records confirmed this.

Requires improvement

Is the service effective?

Our findings

People we spoke with at the home were very positive about the care they received and were happy with life at the home. Relatives we spoke with were also pleased with the care the person received. People's comments included "I don't think I would get anywhere better. The care is good" and "I would recommend it 100%".

We spoke with a nurse and two care staff about the people they cared for. Staff we spoke with demonstrated an understanding of the care people required. We observed staff supporting people throughout the day and from our observations it was clear staff had good relations with the people they cared for.

We reviewed the staff files of two newly recruited staff and saw an appropriate induction into their job role was undertaken. The provider offered a mandatory staff training programme in a range of health and social care topics such as moving and handling, safeguarding, health and safety, food hygiene, managing challenging behaviour, infection control and fire prevention. We saw that the training checklist indicated the majority of staff had completed most of the training in 2015 to enable them to care for people effectively.

We found that no adequate training in dementia, mental capacity (MCA) or deprivation of liberty safeguards (DoLS) was routinely provided to staff to ensure they were able to understand and care for people with mental health needs. When we checked the records, these topics were not listed on the provider's mandatory training programme and staff training records showed that only five staff had attended any training in MCA and DoLS in 2014/2015. During our visit we found that the provision of care in relation to people's mental capacity did not comply with the Mental Capacity Act.

We spoke with two care staff. They told us they felt supported in their job role. Care staff we spoke with told us that nursing staff completed their supervisions and appraisals. When we spoke to one of the nurses on duty about how they were supervised in their job role, we were told nurse colleagues supervised each other. They told us they felt uncomfortable with this as other nurses were colleagues, and not their line manager. When we asked the manager who supervised the nursing team as clinical lead, no clear explanation was given. The previous clinical lead had left the organisation in 2015 and had not been replaced.

When we looked at staff supervision and appraisal records. We found the records did not demonstrate that the provider's staff appraisal and supervision policies were being followed. Supervision and appraisal records were limited and sparse and did not show that all staff had received appropriate support in their job role. For example, the supervision information in respect of three nurses employed at the home showed that they had not received supervision from their line manager since 2014. When we looked at staff appraisal records, we found that only 15 out of 40 staff members had received an appraisal in 2015.

These incidences are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in to ensure staff received appropriate support, supervision and appraisal in their job role.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We viewed the care files of four people who lived at the home. The care files we looked at indicated that people lived with varying degrees of memory loss and confusion. Some people had been diagnosed with dementia.

Where people had dementia or short term memory loss, we found care files lacked any adequate information about the person's capacity to make their own decisions. Some people's care files showed evidence that they had consented to their care plan whereas other did not. We also saw that some consent forms were signed by the person's relatives. The Mental Capacity Acts 2005 states that relatives cannot be asked to sign consent forms when a person lacks capacity unless they have the authority to do so under a Lasting Power of Attorney (LPA). One person

whose care file we looked at contained no evidence that an LPA for health and welfare decisions was in place, yet the person's relative had signed a consent form in relation to their care.

Under MCA legislation, a LPA only comes into force once a person has been assessed as lacking capacity to make a particular decision. None of the people's whose care files we looked had had their capacity assessed in relation to any decisions about their care in order to evidence that the involvement of a LPA was required.

For example, one person's care file indicated they were cared for in bed. Care records documented that a relative had instructed staff to ensure the person was fully dressed in bed during the day. There was no evidence that this had been discussed with the person or that that they lacked capacity to consent to this decision as no capacity assessment had been undertaken. There was also no evidence that any best interest discussions or meetings had taken place.

In the care files we looked at a deprivation of liberty application had been submitted to the Local Authority to deprive the person of their liberty. There was no evidence in any of the files that a mental capacity assessment had been completed. This meant there was no evidence that the person ability to keep themselves safe was impaired.

The manager acknowledged no capacity assessments had been undertaken by them or other staff at the home in accordance with the Mental Capacity Act. This meant there was no evidence that a deprivation of liberty safeguard application was required or justified. There was also no evidence that any best interest meetings or discussions with the person and other people involved in their care, had been held, before the decision to apply to deprive the person of their liberty had been made. This meant that the principles of the MCA and DoLS legislation had not been followed and people's human right to consent to their care had not been respected.

Each person subject to a DoLS application, also had bed rails in place on their bed. Under the MCA and DoLS legislation, the installation of bed rails can be seen as a form of restraint, for which legal consent must be gained from the person themselves if they have capacity, or through the MCA and best interest decision making process if they lack the capacity to do so. There was no evidence that these legal requirements had been adhered to.

We discussed our concerns with regards to the implementation of the MCA and DoLs legislation with the manager during our visit. During our discussions it was clear the manager did not have adequate knowledge or understanding of MCA or DoLS to ensure that this legislation was implemented appropriately at the home to protect people's human rights. This placed people at risk of being unlawfully deprived of their liberty.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's legal right to consent to their care and treatment.

Although the home was pleasantly decorated and well maintained, the environment was not dementia friendly in order to support people who lived at the home with dementia to remain as independent as possible. For example, signage throughout the building was limited and heavily patterned carpets were also in use in some areas of the home. People who live with dementia may find this confusing as they can sometimes interpret patterns in the carpet as holes or steps. Subsequent to the inspection, the provider told us that these carpets were due to be replaced with new flooring which was more suitable to the needs of people who lived at the home with dementia.

People told us the food at the home was good. One person told us "The food is first class. There is plenty of it and it is nicely served. I can't usually eat it all". We were told by people who lived at the home and staff, that a cooked breakfast was always available alongside other choices such as cereal, toast, fresh fruit and yoghurt. We saw that people had a choice of what to eat at mealtimes. The home operated a four week rolling menu and we saw a good range of suitably nutritious food was on offer at all times.

We observed the serving of lunch on day one of our visit. The table was set nicely with linen and china tableware. We saw people had a choice of where to take their meals and the majority had chosen to eat in their rooms. A small group of people sat at the dining room table. On the day of our visit, the meal was roast lamb with fresh vegetables with a choice of several desserts. The food looked and smelt appetising and portion sizes were generous. The mood around the table was relaxed and homely and the whole experience of lunch was unrushed and positive.

Requires improvement

Is the service effective?

We saw that some people sitting in the communal lounge required staff support to eat their meal. Staff provided support in a sensitive and dignified manner, using encouragement and gentle prompting. They chatted to the person they were supporting and ensured the person's meal time experience was a pleasant and interactive one.

We talked to the cook about people's nutritional needs. They had a good understanding of people's dietary needs and preferences. We saw that information about special diets, food consistencies and preferences was available and maintained by kitchen staff. We saw that some people had their diet fortified with cream, butter, extra vitamins and pureed fruit to promote the person's dietary intake

People's care files contained some information about their dietary needs but we found some people's dietary information was difficult to follow as bits of information about their needs were dotted throughout the person's care plan in different sections. For example, one person's Activity of Daily Living' information simply stated they were independent with eating and drinking but required some assistance with cutting up their food. Their toileting care plan however stated that they required a high fibre diet with between one to two litres of fluids daily. A medical care plan also specified the person required a diet rich in iron and restricted protein. From our observations however it was clear that people received a suitably nutritious diet that met their needs.

We saw that people were weighed regularly and medical advice sought if people's dietary intake significantly reduced. People at risk of malnutrition had their dietary intake recorded on food and drink charts. We looked at one person's food and drink information and saw that two different charts were in place. There were no on-going totals of the person's fluid intake recorded and information recorded on both forms did not match. This meant it was difficult to tell whether the person's dietary and fluid intake was accurate or sufficient. This aspect of dietary recording and monitoring required improvement.

Good

Is the service caring?

Our findings

Everyone we spoke with spoke highly of staff at the home. One person told us "I can't speak highly enough of it. The home has very high standards. I can't praise the staff more. They are nice, very patient". A second person told us "I would recommend it 100%. My daughters are delighted" and another said "I don't think I would get anywhere better. The care is good".

One relative we spoke with told us "We feel they are safe here because the care is so good. No-one is neglected". Another relative reiterated this by telling us "They are very comfortable. They wouldn't be with us if they had not been cared for so well".

Throughout the day, we saw staff supporting people at their own pace, talking to people pleasantly and tending to people's needs in a prompt, warm manner. From our observations it was obvious that people felt comfortable in the company of staff. Staff maintained people's dignity at all times and people looked well dressed and well cared for. Relatives were made welcome at all times of the day and visited without any restrictions.

We saw that there were periods throughout that the day when staff took the time to sit with people and have a general chat. The mood was homely, relaxed and appropriate music played softly in the background at various points throughout the day. People and staff were seen to chat either in passing or in a direct face to face conversation about everyday things. This promoted people's emotional well-being. From our observations it was clear that staff genuinely cared about the people they looked after.

We saw that care plans contained some information about what people could do independently and what they needed help with. People were provided with mobility aids to enable them to be independently mobile and we saw that people who were mobile where able to move freely around the building.

Staff we spoke with understood how to promote people's independence and gave clear examples of how they treated people with dignity and respect in the delivery of personal care. One person told us "They (the staff) let me do everything I can". Another person told us, "The staff are very respectful".

We looked at the daily written records that corresponded to the care records we had reviewed. Daily records detailed the support people had received and gave information about the person's general well-being.

We saw that people who came to live at the home were given an information pack when they first arrived. This included information about the home for example, options for meal times, philosophy of the home and its care, the home's statement of purpose and a copy of the provider's complaints procedure. This showed that people had access to adequate information about the home and the services provided. We noted however that the management structure within this information pack was out of date.

People we spoke with told us that resident meetings took place to keep them informed of any news in relation to the running of the home. People said they felt able to feedback their views and suggest ideas for improvements during these meetings. We reviewed the minutes of these meetings in August and November 2015. We saw that any actions resulting from these meetings were recorded and acted upon where possible.

We saw the home had achieved Beacon status in the Gold Standards Framework for Care Homes. We saw that people's future wishes in respect of cardio pulmonary resuscitation in the event of ill health had been discussed and planned for. The home monitored people's health and well- being in relation to their end of life wishes. There were appropriate anticipatory end of life medicines in place to alleviate people's pain and discomfort should they require end of life medical care. We saw that people's relatives had sent in thank-you cards praising the staff for the quality of the end of life care provided to their loved ones.

Good

Is the service responsive?

Our findings

People who lived at the home told us that it was entirely their choice when they got up, what they had for breakfast, what activities they engaged in and what they did with their own time.

People told us that staff responded to their needs promptly and they were well cared for. One person told us "I feel secure here. They check you at night. I have a call bell and they respond within a minute". Another person said "I have no complaints I am well looked after".

A relative we spoke with told us how staff at the home had adapted the support the person received to meet the person's changing needs. They said "They don't dress them (the person) now because they get distressed. The care has changed as their needs have changed".

Staff we spoke with knowledgeable people's needs and the day to day care they required but we found this information was not well documented or explained. We saw that each person's care file contained an assessment and care plan. We found however that care files lacked sufficient person centred information and some care plans were generic to a number of people rather than personalised to the needs, risks and preferences of each individual. This aspect of care planning required improvement so that staff had clear information about people's individual needs and preferences.

During our visit, we observed staff meeting people's needs in a kind and compassionate manner. Staff were attentive, polite and pleasant in all interactions. We observed some examples of good person centred interactions for example, during lunch, we saw one staff member telling a person a poem whilst encouraging them to eat. It was obvious by the person's facial expression that they enjoyed this and it was clear that the staff member had made a positive connection with the person whilst they provided support.

It was clear in people's care records that referrals to other healthcare professionals where made in support of people's health and well-being needs as and when required. Records showed that people received appropriate support from GPs, chiropody, opticians, community dieticians, district nurses and speech and language therapists. We saw that records of any healthcare professional visits were documented in people's professional visit notes for all staff to read. It was clear that people had prompt access to medical and other healthcare support.

People we spoke with told us that there were a range of activities on offer to occupy and interest them. One person we spoke with told us "They have staff who come in and entertain us. One comes with games, scrabble and we did Easter bonnets today!". Another said "There are things to do when you are in the mood".

A relative we spoke with also told us "They always have nice music on for them. They have activities but not lots of participations. They prefer to stay in their rooms. The Vicar comes in every Sunday to give them Communion".

The provider employed an activities co-ordinator who organised a wide variety of activities for people who lived at the home to participate in. Activities such as board games, morning walks, group quizzes, trip outs to the Bacon Butty a local church group and pampering sessions. On the days we visited, a small group of people enjoyed a craft session and a large group of people enjoyed a game of Hangman in the communal lounge. These type of activities ensured that people's social needs and interests were catered for.

All of the people and relatives we spoke with had no complaints or concerns about the care they received. One person told us "I have no complaints. I am well looked after". Another said "If I had a problem I would mention it to the nurse co-ordinator. They would pass my comments onto the manager".

The provider's complaints policy was provided to people on admission. It was also available in the information folder located in the entrance area of the home. The policy itself was however not visibly displayed. We spoke to the provider about this, as this is a legal requirement. The provider assured us they would rectify this without delay. On reviewing the provider's complaints policy we saw that there were no contact details provided for the provider to whom complaints should be directed in the first instance.

We looked at the provider's complaints records and saw that no complaints had been received by the home since 2013.

Requires improvement

Is the service well-led?

Our findings

The provider was the registered manager of the home at the time of our visit. People who lived at the home, staff and relatives referred to the provider as the manager in any conversations held with us.

We saw that the manager and staff undertook a range of regular audits to monitor the quality and safety of the service provided at the home. This included an audit of care plans, health and safety, environmental audits, accident and incident audits and medication audits. We saw where actions for improvement had been identified, the majority of these had been undertaken and the issues resolved. However some of the audits undertaken were ineffective.

We found a number of inconsistences in people's care records about their needs and risks. Care plans and risk assessment were also generic and sometimes not personalised to the individual and people's nutritional information was inconsistent. When we asked one of the nurses about the care plan audits in place, they told us that they were responsible for assessing the quality of their own care plans. This meant that there was no evidence that the manager had any oversight with regards to the care plans developed or that they monitored the quality and accuracy of these care plans to ensure they provided adequate, easy to understand and up to date information. Other information in relation to people needs was also insufficient for example personal evacuation information.

Accidents and incident audits were in place but were too brief to enable the analysis of trends for example, location and time of accident/incidents, type of accident/incident and staff on duty. This meant that there were no effective learning systems in place to identify, assess and manage the risks posed to people using the service from similar incidents occurring.

Policies and procedures in some instances were not adhered to by staff or the manager. For example, the provider's medication policy clearly stated the safe administration procedure for staff to follow was to dispense the medication using a medicine measure or plastic cup 'without touching the medication'. From our observations it was clear some staff were not adhering to this policy. By not doing so, they placed people at risk of harm.

The providers' bed rail policy clearly stated that the reason for the use of bed rails would be documented, a risk assessment determining their risk of use completed and the person's consent obtained, prior to, the decision to install bed rails was taken. It was clear from the records and the manager's own acknowledgement that this policy had not been followed.

We found that the knowledge of the manager and staff at the home in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards was limited. The manager did not have a full understanding of this legislation and their responsibilities within it and by consequence its implementation at the home was poor.

These examples demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to have effective systems and processes in place to assess and monitor the quality and safety of the service provided.

Most of the people who lived at the home and their relatives told us they knew the manager and said they were a visible presence within the home. People who lived at the home told us "The manager passes by. They are always accessible", another said "The manager is very nice. You can talk to them. I would recommend the home to other people". Relatives we spoke with also spoke highly of the manager and staff at the home.

During our visit we found the culture of the home to be positive and inclusive. We observed lots of positive interactions between staff and people who lived at the home. Staff were kind, caring and compassionate in all aspects of the care delivered. Visitors to the home received a friendly, warm welcome and were treated with genuine hospitality. Staff were observed to have good relations with each other, had a positive work ethic and worked well as a team.

We saw that questionnaires seeking feedback from people who lived at the home, relatives and other healthcare professionals were sent out regularly to assess and monitor the quality of the service provided. We reviewed a sample of the questionnaires completed in 2016 and saw that positive feedback was received in respect of the care provided.

Requires improvement

Is the service well-led?

At the end of visit, we discussed some of the areas for improvement identified during our inspection with the manager and two nurses and two administration staff who were invited to the feedback by the manager. We found all parties to be open and receptive to our feedback. They took on board that some improvements were required and demonstrated a positive attitude to continuous improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There were no suitable arrangements in place to ensure that the service obtained the consent of, and acted in accordance with the consent of people who lived at the home. Regulation 11(1),(2),(3) and (4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The assessment and care planning of people's individual needs and risks did not ensure that safe and appropriate care was provided as people's needs and risks had not been fully identified or mitigated against in the delivery of care. Regulation 12(1),(2)(a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess , monitor and mitigate the risks to the health, safety and welfare of people who used the service. Regulation 17(1),(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have suitable arrangements in place to ensure all staff received appropriate supervision and appraisal in relation to their job role.

Regulation 18(2)(a).