Care UK Community Partnerships Ltd

Armstrong House

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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 26, 29 and 30 October 2015 and was unannounced.

We last inspected this service in May 2014. At that inspection we found the service was meeting all the legal requirements in place at the time.

Armstrong House is care home for older people, some of whom have a dementia-related condition. It provides nursing care. It has 71 beds and had 60 people were living there at the time of this inspection.

The service had a registered manager who had been in post for nearly two years. However, this person had been on sickness leave and tendered their resignation to the provider in the course of this 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.

We found some of the systems in place to ensure people received their medicines safely were not effective and could put people at risk.

Summary of findings

Other risks to people were appropriately assessed and managed. Accidents and incidents were analysed and actions were taken to minimise the chances of them re-occurring.

Robust staff recruitment processes were in place to ensure applicants were properly assessed as to their suitability for working with vulnerable people. There were enough staff to meet people's needs safely.

The staff team was experienced and skilled. Staff knew people's likes, dislikes and needs well.

Staff had not been given the ongoing training they needed to keep their knowledge up to date. Nor had they been given the necessary support, in terms of supervision and appraisal.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the registered manager was familiar with the processes involved in the application for a Deprivation of Liberty Safeguard. At the time of the inspection 13 people living in the home were subject to the Deprivation of Liberty Safeguards.

People's needs were not always fully assessed before they came to live in the home. People and their relatives were involved in assessing their needs on admission and in drawing up plans to meet those needs. Social and spiritual needs were not fully considered, however.

Care plans were not always kept up to date or robustly reviewed.

People told us they felt staff listened to them and issues were resolved. Formal complaints were not always properly investigated or recorded in sufficient detail.

A good range of social activities was made available to people. However, arrangements for ensuring people regularly left the home for trips or other leisure activities were poor.

The management of the service had been inconsistent in recent months. Although a system of audits had been rigorous in identifying areas for improvement, the required changes had not always been followed up and achieved.

We found breaches of Regulations regarding safe administration of medicines; supporting staff; consent to care and treatment; person-centred care; complaints; and governance.

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. The arrangements for supporting people with their medicines did not fully guarantee their safety.

People were protected from abuse by staff who were trained in and knowledgeable about safeguarding them.

Risks to people were assessed and appropriate measures taken prevent avoidable harm.

There were sufficient numbers of staff to meet people's needs safely.

Is the service effective?

Requires improvement

The service was not fully effective. The staff team was experienced, skilled and knowledgeable, but had not been given all the training they required to meet people's needs.

Staff had not been given the proper support to carry out their roles effectively.

People had not always given their formal consent to their care.

Staff responded appropriately to changes in people's health needs and ensured a nutritious diet was taken.

Is the service caring?

Good

The service was caring. People told us they were very happy with the caring nature of the staff, and felt they were treated as individuals.

Staff demonstrated a sensitive and caring manner in their interactions with people, and listened to what they said.

People's privacy and dignity were respected.

Is the service responsive?

Requires improvement

The service was not fully responsive. People's needs were not always assessed before they came to live at the home, and insufficient attention was paid to the assessment of their social and spiritual needs.

People's care plans were not always kept up to date and were not reviewed robustly.

The system for recording and responding to complaints was not effective.

A range of suitable activities was available, but people were rarely taken out of the home for leisure purposes.

Is the service well-led?

Requires improvement

The service was not well led. The registered manager had just tendered their resignation.

Summary of findings

Quality monitoring systems had identified deficits in the service but these had not been fully addressed. Care records and other documentation were not fully up to date.

There was an open culture in the service that sought and acted upon the views of people, their relatives and staff.

Armstrong House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26, 29 and 30 October 2015. The inspection was unannounced.

The inspection team was made up of one adult social care inspector; an expert-by-experience; and a specialist nursing care advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities, clinical commissioning groups and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we toured the building and talked with 13 people and five visiting relatives. We spoke with 18 staff, including the regional manager, the operations manager, a support manager, two registered nurses, two senior care assistants, four care assistants, two domestic staff, two kitchen assistants, the activities organiser and a visiting hairdresser. We 'pathway tracked' the care of four people, by looking at their care records and talking with them and staff about their care. We carried out a 'short observational tool for inspectors' (SOFI) to gather the experiences of people who could not communicate with us verbally. We reviewed a sample of ten people's care records; six staff personnel files; and other records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with said they felt safe and protected from harm in the home.

We looked at the management of medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. The staff member checked people's medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines. The MARs showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. However, we saw gaps in the topical medicines application records for four people. We saw that photographs of four people on one nursing unit were missing from their MARs, which meant there was a risk of mistakes of identity when administering medicines.

Medicines were generally stored safely and securely. However, we saw that one medicine was stored in the fridge, when this was not required, which meant that it was not stored under the required conditions.

The service had a medicines policy in place dated August 2013 with a review date of August 2016. We saw reference to the Royal Pharmaceutical Society of Great Britain 'The Handling of Medicines in Social Care'. However we did not see reference to the recognised National Institute for Health and Clinical Excellence (NICE) guidelines on managing medicines in care homes, to ensure that medicines were managed in accordance with current regulations and guidance.

We were told that two people received their medicines covertly (without their knowledge). However, we did not consistently see that a best interest meeting had taken place with the General Practitioner (GP), the next of kin, the pharmacist and the care home staff. This meant that the decision making did not adhere to the NICE guidelines.

Audits of medicines were conducted internally and by the supplying pharmacy. Recent audits had identified a range of areas for improvement, including updating checks of staff competency in administration of medicines; MARS to be updated with allergy status; ensuring the date of opening was recorded on containers of liquids, creams and drops; and giving instructions to staff about how to administer covert medicines. Records did not show such issues had been addressed since the audits.

These were breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service had a policy for safeguarding people from abuse, and posters were displayed around the home reminding people and staff how to report any abuse. A log was kept of safeguarding incidents, but we saw not every safeguarding notified to the Care Quality Commission had been recorded in the service log. Staff told us they received training in safeguarding issues and were confident that any suspicion of harm to people would be reported immediately. The service had a pro-active policy, entitled "If in Doubt – Raise It!" which encouraged staff to report any bad practice by colleagues.

Both general and individual risks were assessed. Overall environmental risks of, for example, slips and falls, burns, moving and handling equipment and chemicals used for cleaning were monitored and appropriate control measures were put in place. People's individual risk factors were identified and specific plans for supporting people with, for example, their mobility needs/transfers were in place. One person's mobility plan detailed that care staff should "use a stand aid to transfer and requires the assistance of two staff, [Person] has no sitting balance and uses a wheelchair to mobilise any distance with the aid of one staff member."

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, security, and water temperature and quality. Up to date contracts were on file for the routine maintenance and servicing of equipment.

Plans were in place for responding to emergencies such as fire, evacuation of the building and the failure of essential services. Each person had an emergency evacuation plan on their file. Staff trained in first aid were available on every shift. Two staff were moving and handling trainers.

A separate accident and incident book was kept on each unit. Such events were analysed on a monthly basis (although had not been in the previous three months), looking for trends with regard to individuals, location and

Requires improvement

Is the service safe?

times. People prone to frequent falls were identified and referred to their GP for review. We saw advice and input from the falls team and challenging behaviour team was recorded and added to people's care plans.

The operations manager told us staffing levels in the service were calculated using a tool that assessed the dependency of residents. This tool was completed at least monthly, and whenever there was a change to the numbers of people living in the home. We noted that, in practice, the dependency tool had not been completed in the three months prior to this inspection. However, as occupancy had dropped by six people and the staffing levels had remained unchanged, we found the staffing levels to be satisfactory. Our observations were that staff were able to attend to people's needs without undue rush. Staff confirmed this. A nurse told us, "Staffing is generally okay. We always try to get cover for staff sickness, and staff support each other." A care worker said, "There seems to be enough staff. We can meet people's needs." A relative commented, "There's enough staff and the atmosphere is very calm. I've seen no problems."

Robust staff recruitment processes were in place to ensure applicants were properly assessed as to their suitability for working with vulnerable people. Systems included checking any criminal convictions the applicant might have had; taking up references from previous employers; exploring the applicant's employment history and asking for various types of proof of the applicant's identity.

Requires improvement

Is the service effective?

Our findings

People told us they felt their needs were generally effectively met. A relative said, "We couldn't have chosen a better home." A second relative said, "The staff are capable. They know what they are doing." A comment from a relative in the service's compliments file stated, "Staff have the knowledge and insight into the care of people with palliative care needs and dementia. [Named staff] have gone above and beyond and shown so much care and attention."

The service had 10 Registered General and Mental Health Nurses who attended regular courses to update skills and cascade information to staff. Two care staff held 'train the trainer' qualifications in moving and handling; and two other staff were Care Certificate Assessors. Fifteen of the 40 care staff had either achieved, or were working towards, Diplomas in Health and Social Care, at levels two, three and five.

Staff we spoke with displayed a good level of knowledge of their roles and responsibilities, and of the needs of individual people in the home. We observed staff were skilled in working with people living with dementia. They showed good communication skills and were alert and responsive to people's needs and wishes.

A number of staff had been given roles as 'champions' in different areas of care including dementia, stroke, nutrition, dignity and mouth care. Several spoke enthusiastically to us about these roles and told us how they advised other staff on assessments and care planning in their particular specialities. A mouth care champion said, "In my training, I've learned about ulcers, cleaning and denture care, thrush and the effects of medicines on the mouth."

Staff were able to access resource files which contained detailed information and guidance on meeting the needs of people with a wide range of medical conditions. We were told staff received excellent support from an older person's nurse specialist who was attached to a local GP practice. One staff member told us, "The nurse specialist is on call and responsive to requests for advice. They facilitate us in getting prescriptions quickly and give us training in areas such as the use of nebulisers." We were told the nurse specialist also arranged for other professionals to give staff training in topics including Parkinson's and cognitive behavioural therapy.

We were told that all new staff had, from July 2015, been enrolled automatically on training for the Care Certificate. Achieving this qualification was mandatory in passing their induction/probationary period.

Staff told us they received regular training opportunities and benefitted from the training they received. Several spoke highly of the dementia care training they had been given. They told us it had given them much greater insight into people's experiences of dementia and allowed them to address people's distressed behaviours with more skill and empathy. One care assistant said, "The 12 week dementia course was brilliant, I learned loads."

When we examined the records kept of staff training, however, we found significant gaps in the training matrix and records. For example, 24 of the 74 staff were not up to date with safeguarding adults training; 30 were not up to date with fire training; 22 staff with mental capacity act training; and 43 staff with dementia/fulfilling lives training. We saw the deficiencies in the staff training programme had been identified in recent internal audits and the manager at the time instructed by the provider to rectify these omissions, as a matter of high importance. The most recent audit showed that these training targets were, however, still outstanding.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider's policy for supporting staff included a commitment to providing a minimum of six supervisions sessions and an annual performance appraisal each year. Staff told us they felt they had sufficient support but were not clear how often they should receive supervision. One care assistant thought it was "every two or three months". A senior care assistant told us, "If a member of staff needs more supervision, they get it." We saw that a structured supervision tree had recently been introduced, setting out responsibilities for giving supervision, and a structured agenda introduced. However, records of staff supervision showed that this was not given at the frequency set down in the policy. The majority of staff were recorded on the supervision matrix as having received only one supervision session in 2015. Records of appraisal showed that only 12 members of the total staff group of 74 had been appraised in 2015.

Requires improvement

Is the service effective?

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Daily notes were kept for each person. They were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition. Staff handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty, at the beginning and end of each shift. Information about people's health, moods, behaviour, appetites and the activities they had been engaged in were shared, which meant that staff were aware of the current state of health and well-being of people. We saw staff signed a daily log which acknowledged that they knew and understood people's needs and their responsibilities and actions they should take.

Communication care plans were in place and we saw specific details for staff to follow in relation to how they engaged with people. For example, one person's communication plan stated "[Person] can sometimes try to use yes and no responses, but these are not consistent, [Person] is able to use facial expressions and hand gestures to help when communicating". This individualised approach to people's needs meant that staff provided flexible and responsive care.

We looked at how the service complied with its responsibilities under the Mental Capacity Act (MCA) 2005. Records confirmed that, where necessary, assessments had been undertaken of people's capacity to make particular decisions such as agreeing to reside in the home. Where the person was deemed to lack capacity, we saw the person's family and staff at the home were involved in their best interest decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS are legal safeguards to protect the rights of people who may lack mental capacity to make some decisions around their care and welfare. Records showed that assessments had been undertaken to check whether the person's care plan would amount to a deprivation of their liberty. Where this was the case, a written application was submitted to the local authority.

Consent to care and treatment records were signed by people where they were able; if they were unable to sign, a relative or representative had signed for them. However, we were unable to see consent records for two people. We saw examples of where the question 'Is the person able to express their wishes and contribute to the care plan?' had been left unanswered and consent forms left unsigned. We asked how people were able to confirm their consent on computer-based documents. We were told an original paper copy was signed and kept on the person's file, but we saw few examples of this in practice. We saw other examples of where people had signed their consent to actions such as the taking of their photograph for identification purposes, but not to their personal care.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. An example for one person stated "soft/ normal diet, syrup fluids give assistance with eating and drinking by one carer if necessary, to be taken to dining room so staff can supervise their eating pattern, [Person] to be fully upright when feeding, evaluate care plan monthly or as condition changes, food/fluid charts to be completed daily to ascertain total daily intake".

Choking risk assessments, food and fluid balance charts and weight charts were in place. Records included notification to the kitchen regarding people's food likes, dislikes and dietary needs. Referrals were documented to relevant health care professionals, such as GPs, dieticians and speech and language therapists, for advice and guidance to help identify any issues.

All those we spoke with were pleased with the food on offer although one person told us the menu was a bit repetitive. Another person said, "I eat everything. It is so good." The menu alternatives were pointed out to people to help them make their meal choice, and there was good access to drinks on each table. One person had particular religious food requirements. This person told us these were always met, as were other cultural needs.

Requires improvement

Is the service effective?

People's records showed details of appointments with and visits by health and social care professionals. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), district nurse teams, social workers and community behavioural team. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various health and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

All the people we spoke with were very pleased with the care they received. One person said, "I am treated very well." A second person commented, "The staff are nice to me". Another person told us, "The staff are very good and cheerful. They are so helpful." Other comments received included, "They are nice lasses (staff). The men (staff) are nice, as well"; and, "The staff are very friendly and they meet my needs. This place is very free and I can have visitors as I choose." A relative told us, "It is beautiful here. The staff are amazing. My relative is well cared for. The staff will do anything to help them. Nothing is a trouble." A second relative commented on the "Caring atmosphere" in the home.

We saw, in the service's compliments file, comments including, "Excellent care received"; "You gave my relative support, love and attention"; "Lovely lasses and smashing lads (staff)"; "What an amazing, caring, compassionate team you are"; and, "We cannot thank you enough for your dedicated care."

We noted a warm, inclusive atmosphere in the home. We saw staff were polite, friendly, patient and caring in their approach to people and their relatives. They carried out their tasks in an unhurried manner. They talked with the person and explained what they needed to do (for example, when transferring people from wheelchairs to armchairs in the lounge), and offering reassurance, where required. Relationships between staff and people in the home were clearly based on mutual respect and affection. Staff and people were at ease in each other's company, and smiled and chatted freely.

Each person's care record contained a social profile (My life story), where the information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This enabled staff to better respond to the person's needs and enhance their enjoyment of life.

We found that care records reflected some personal preferences and wishes. Examples included "Invite [Person] to join in any group activities/entertainment within the home or [Person] to be given one to one time with the activities co-ordinator if they wish." For another person we saw the following example "[Person] enjoys chatting to staff and family and listening to music, to be encouraged to participate in in-house entertainment and activities to motivate [Person] and keep their mind active". This was helpful to ensure that care and support was delivered in the way the person wanted it to be.

A key worker system was in place. A key worker is a named member of staff who some specific responsibilities for the well-being of a small number of people in the home. These included giving extra time and attention to the person, liaising with their relatives, and checking if they needed new clothes or toiletries. A photograph of each person's key worker was displayed in each person's bedroom, with their permission. People's well-being was also enhanced by attention to their personal care in their care plans. A hairdresser visited the service twice a week. A relative told us, "Personal care is very good. (My relative) thrived here. It gave us complete peace of mind."

The service had a policy on equality and diversity which aimed at making everyone feel welcome in the home and able to express their individuality freely. Staff were aware of people's personal, cultural and religious requirements. People we spoke with confirmed they were able to practice their faith and were supported with any dietary and other cultural needs they had. Where appropriate, people's families had been approached for advice on their customs and practice. A church service was held monthly in the home, and Holy Communion was available on request.

We saw staff made good efforts to involve people in decisions about their care and the running of the service. For example, the staff member administering medicines explained to people what medicine they were taking and why. Staff also supported people to take their medicines and provided them with drinks, as appropriate, to ensure they were comfortable in taking their medication. We noted that the staff in one dining room were asking people for their opinions on a forthcoming refurbishment of the home, and what their preferred colour schemes would be. The operations manager told us people considering coming to live in the home were encouraged to visit before making their decision, and were able to take a meal with people and stay overnight if they wished. Regular meetings were held for people and relatives to give their views and suggestions, and there was an annual survey of their views.

We were told the provider had a 'dementia strategy', and a company dementia specialist was being brought in to develop the service's approach to meeting people's needs.

Good

Is the service caring?

Efforts had been made to make the environment suitable for people living with dementia, with large signage for toilets and bathrooms. Different areas of the home were decorated with themes such as shops, beach and sea-side, and cinema stars, to aid people's orientation. 'Memory boxes' (used to display personal items that helped people find their own rooms) were in place, but had yet to be personalised. A number of care staff had been designated 'dementia champions' to model good practice and advise other staff. The operations manager told us relatives had been invited to attend education sessions on caring for people living with dementia as part of the home's open days.

We saw information about advocacy services was displayed in the home. We saw documentary evidence of the use of Independent Mental Capacity Advocates. These are independent and objective advocates. They represent people who lack the capacity to make important specific decisions about their lives, such as where they live and about serious medical treatment options, and have no one else to represent them.

Staff told us respecting people's privacy and dignity was central to everything they did. One care assistant said, "It's only by listening to people with dementia and respecting their dignity that we can gain their trust enough for them to tell us about their needs, for example when they need to go to the toilet." We noted that the staff observed people's privacy and always knocked on the door of bedrooms before entering. We saw that people who had dropped food on their clothing were asked if they wished to be helped to change their clothes.

Care plans showed a commitment to helping people stay as independent as they were able. For example, one person's care plan stated, "Provide independence by giving (person) a flannel to wash their face. (Person) is able to dress themselves, but allow them time to do this." We were given examples of people who had regained a significant degree of independence since entering the home. One person who had been cared for in bed on admission with pressure damage to their skin was now able to walk, attend to personal care, had regained continence and skin integrity.

Three people required assistance with their meals. Care workers helped them very competently and patiently, with no sense of rush. We noticed the friendly atmosphere both in dining rooms and lounges. There was evidently a good rapport between staff and people. One person told us, "I like it here. I get to do what I want. The staff are always good".

Records showed that the relevant people were involved in decisions about a person's end of life choices. When a person could no longer make the decision themselves, we saw that an Emergency Health Care Plan was in place for a person that showed a 'best interest' meeting had taken place with the person's family and the GP,to anticipate any emergency health problems. However, for one person we saw the following record in their end of life care plan "Wife will decide on any future plans when the time comes"; we saw no mental capacity assessment/best interest decisions noted. A relative of a recently deceased person told us, "A carer sat up all night with (my relative) holding their hand until they died. They met all (my relative's) needs."

Requires improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us they felt the service was responsive to their wishes and needs. One person said, "I have no complaints. They come right away." We observed staff were alert to signs of discomfort or discontent, and responded quickly when people rang for assistance.

We looked at how the service assessed people's needs. We found no evidence of pre-admission assessments, although staff told us such assessments may have been archived. If such pre-admission assessments were not carried out, it meant that the service may not have been fully aware of people's needs before they arrived at the home may not have had the resources or staff skills to meet those needs. This put people at risk of distress if the service decided their needs could not be fully met after they had been admitted to the home.

The service carried out a range of needs assessments on a person's admission to the service. These included: a dependency assessment; a care needs assessment, which included information regarding personal care, hygiene support, and continence needs; a falls risk assessment; manual handling; night care; nutrition; skin integrity; and weight. Other assessment documentation was used as required (for example, if the person had epilepsy).

Following this initial assessment, care plans were developed detailing the person's care and support needs, and actions and responsibilities of staff, to ensure personalised care was provided to all people. We saw the care plans covered all the needs identified in the person's assessment, other than for social and spiritual care.

Staff were alert to the risks of people being socially isolated in the home. We saw examples in the care needs summary such as, "(Person) is at risk of feeling isolated and withdrawn." However, staff were hampered in meeting those needs fully by the lack of specific assessments and care plans regarding social and spiritual needs in the provider's methodology. The social profile used was completed separately from that assessment methodology and did not prompt the drawing up of a social care plan to address identified social care needs For example we saw it had been identified, "When (person) is low in mood, they can socially isolate themselves from others", but we found no corresponding care plan for preventing social isolation.

Similarly, although there was a basic question regarding 'ethnicity' and 'religion' in the initial assessment, there was no specific assessment of people's spiritual needs and practice, and no corresponding care plan.

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

We were told that care planning system was a computerised system 'Caresys', which was a fully integrated care home management software solution designed to add value to care organisations. We were told that care records/ risk assessments were printed off when they were updated on a monthly basis. However, we saw inconsistencies in record keeping, both within the computerised system (where assessments were not always completed on a monthly basis) and between the computer records and the printed paper care records (which should have been consistent). Staff we spoke with were unable to explain these gaps and inconsistencies.

We saw evidence of the formal involvement of the person and/or their family in some, but not all, of the care records examined. Records for two people showed that the person and relatives had not signed the care planning documents. This meant that people may not have been consulted about their care, and thus the quality and continuity of care may not be maintained.

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

We noted the service did not have a specific document for reviewing people's care. Instead, it relied on a section at the end of the care plan that asked for 'Any objections?' and 'Comments'. We felt this did not facilitate a pro-active and thorough approach to reviewing people's care.

The service had an activities co-ordinator. This person was spoken of highly by people, their relatives and staff as being enthusiastic, imaginative and hard-working in meeting group social needs. We were given many examples of the social activities available to people. These included games (including quoits, ball games, bingo); activities (such as baking, sing-a-longs, reminiscence sessions and making decorations for parties and events); social events (coffee mornings, wine and cheese party) and exercise, including

Requires improvement

Is the service responsive?

Tai Chi. The activities co-ordinator told us they spent as much time as possible in one-to-one activities with people, particularly with people being cared for in bed, but this time was necessarily limited.

Several people told us they enjoyed the garden and its facilities, and said they liked to sit out there on good days. When possible, the activities co-ordinator took people out to the local shops. Several people told us how much they appreciated the energy and commitment of the co-ordinator. One person, "It is not dull here. And the staff are very friendly." A visitor said, "It's a very nice home, full of busy, and lots of activities going on."

We noted, however, that people rarely left the building unless accompanied by relatives. This was particularly so in the unit for people living with dementia. Staff we spoke with confirmed this.

Staff told us they always tried to give people as much choice as possible in their daily lives. They gave examples such as when the person wished to rise and retire; how they wanted their care at night; how they dressed; what they ate, and where (for example, breakfast in bed); where to spend their time; and whether to join in activities and accept visitors.

The service had a policy for responding to complaints. This was referred to in the 'service user guide' given to people and their relatives, but was not in sufficient detail to facilitate its use by people. A log was kept of complaints received, and the response of the service, but we saw no complaints had been logged between January 2014 and September 2015. Other records showed complaints had been made to the service in that period. Complaints records varied in their quality and completeness. A minority of recorded complaints had been responded to professionally and in good detail, and showed evidence of investigation and outcome. Other complaints had not been logged in detail (or, in one example, at all) and it was not clear what, if any, steps had been taken to resolve them. This meant we could not be assured the service responded to complaints appropriately.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager in post. However, the registered manager tendered their resignation to the provider in the course of this inspection. In addition, we were told, the deputy manager had been on sickness leave for the previous two months. The service was being managed by a peripatetic manager, with support from another operations manager. The peripatetic manager told us the previous registered manager had agreed to apply to have their registration cancelled.

People told us they were happy with the way the home was run. They told us the recent change of management had not had a big impact on them, and that their care continued to be good. They told us they felt listened to and that staff acted on their views. Relatives also expressed satisfaction with how the service was run. One relative told us, "This Home was recommended to my family and we moved my wife from another Home to this one. I am very satisfied and so pleased we did so. My daughter is also very satisfied." Another relative said, "We are always made welcome. We are very positive about the home." A visitor commented, "I take my hat off to the staff, it's a well-managed home."

We found genuine attempts by the provider to be provide a culture of openness and inclusivity for staff. Staff told us senior managers visited the home and were open and accessible to staff. Staff told us they felt respected and listened to by the management. One staff member told us, "We are given excellent support and help, even with personal issues, which boosts our confidence. They are sensitive to staff needs." Another staff member said, "The company makes allowances for family commitments. There's good 'give and take'." Staff were able to access the provider's intranet which allowed them to read company policies and other guidance, read company news and give their views. Memos regarding 'lessons learnt' were distributed around all homes following outcomes within other homes in the company. Staff told us they were encouraged to question practice and we were told of the company's 'Gem' staff awards system for recognising exceptional practice or innovation.

There was a positive culture in the staff group. One staff member told us, "Staff support each other in the unit and between the units. We are all one big team." A second staff member said, "Senior management listen and respond." Staff were open and honest with us and took an obvious pride in their work.

Staff meetings had been held regularly earlier in the year, but we noted the last one had been four months ago. Minutes showed staff had been given clear messages regarding their roles and responsibilities, and had been thanked for their hard work and suggestions for improvement. We were told attempts were made to hold meetings for relatives, but two had been cancelled due to lack of support from relatives.

Staff told us many people in the home had previously lived in the immediate locality and the service was keen to maintain people's links and to be a local community resource. There were links with local churches and schools, and the service welcomed young people from schools for work experience. Weekly trips were arranged to allow a small number of less dependent people to attend activities at a local community centre.

The views of people in the home, their relatives and staff were surveyed annually. The most recent staff survey (October 2015) showed high levels of staff pride in their work; clear understanding of their roles; and the identification of people's care as being the top priority in the service. Overall, results showed a significant increase in staff's positivity about their role and the service provided since the previous survey.

A relatives' satisfaction survey was carried out by telephone every three months. The most recent survey showed 85% of respondents were satisfied with the overall service provided.

Record keeping for people was of variable quality and up-to-date written information was not always available for staff to respond to people's changing needs. The operational manager was, for example, unable to find the records showing audits of care documentation. Other examples included failure to update some risk assessments, reviews and other care documentation; gaps in records such as food and fluid intake charts; missing signatures and dates on documents; and a failure to transfer information from paper documentation onto the main computerised recording system.

The service had a range of quality monitoring systems in place. Monthly audits were carried out by the provider's

Requires improvement

Is the service well-led?

regional director, and at least annually by the provider's clinical governance team. These audits were thorough and areas for improvement or further development were clearly communicated to the registered manager, who was required to compile a service development plan to address any deficits in performance. External audits of the service were conducted periodically by agencies such as the local authority commissioning and environmental health teams, and the service's contracted Pharmacist. The registered manager had responsibility for auditing a range of areas including health and safety, medicines, nutrition, infection control, care documentation and the overall effectiveness of quality systems.

We noted, however, that the service development plan had not been fully effective in bringing about the required changes, and similar issues of concern were noted in successive monthly monitoring visits. These included staff training, supervision and appraisal; management of medicines; and care documentation.

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

Discussions with the regional manager, the operations manager and the support manager showed they had a full appreciation of the impact of the problems caused by inconsistent management of the service over recent months. They told us they would fully assist the newly appointed manager in addressing the identified deficits in the service, and give the supervision, support and resources required to achieve this.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services and others were not protected against the risks associated with unsafe management of medicines.** **Regulation 12 (2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Persons employed by the provider had not received appropriate support, training, professional development, supervision and appraisal.** **Regulation 18 (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not obtained the consent of people to their care and treatment.** **Regulation 11 (1)(3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

A full assessment of all the needs and preferences of people using the service had not been carried out; and care plans did not fully reflect people's needs and preferences regarding their care and treatment.

Regulation 9 (3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Effective systems were not in place to investigate, record and take necessary and proportionate actions taken in response to complaints received. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems to assess, monitor and improve the quality and safety of the services provided and the risks to people using the service were not effective; and accurate records were not kept in respect of each person. Regulation 17 (2)(a)(b)(c)