Care Quality Commission

Care Uk Community Partnerships Ltd

Hadrian 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?	Good

Overall summary

The inspection took place on 3 and 5 November 2015 and was unannounced. This means the provider did not know we were coming. We last inspected Hadrian House in October 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Hadrian House provides personal care for up to 63 older people, including people with dementia related conditions. Nursing care is not provided at the home. At the time of our inspection there were 56 people living at the home.

The service had a registered manager. 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 that risks to personal safety were assessed and managed to prevent people from coming to harm.

Summary of findings

Relatives told us they felt their family members cared for safely. Staff had a good awareness of their responsibilities to safeguard people from abuse and knew how to report any concerns about poor or unsafe care.

New staff were properly recruited to ensure they were suitable to work with vulnerable people.

On occasions, the numbers of staff and the ways that staff were allocated affected the consistency of the service that people received.

People were supported to receive health care services, maintain their health and to take their prescribed medicines safely. People's nutritional needs were assessed and monitored. However, menus were not being followed, mealtimes were disorganised, and people did not always receive the support they needed with eating.

Staff were given training and supervision to help them meet people's needs. Staff told us they felt well supported in their roles and personal development.

People living with dementia were cared for effectively, though a dementia-friendly environment had not yet been fully developed. We have made a recommendation about enhancing the environment. People's rights under mental capacity law were understood. Formal processes were undertaken when people lacked capacity to make important decisions about their care and treatment.

Staff were caring and respectful in their approach and provided people with dignified care. All staff we spoke with had a good understanding of people's preferences and how they wished their individual care to be given.

People had personalised care plans drawn up for meeting their needs. Care was adjusted in response to changes in needs and when other professionals gave advice. People and their families were involved in decisions about care planning and in reviewing care and support. Any complaints about the service were appropriately responded to and thoroughly investigated.

Limited activities had been made available to meet people's social needs whilst a new activities co-ordinator was being appointed. We have made a recommendation about providing regular social stimulation.

The registered manager provided leadership within the home and was committed to promoting an open and inclusive culture. Checks and audits of different areas of the service were conducted to make sure standards were being met. Action plans were in place for making improvements to the quality of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to staffing and meeting people's nutritional needs. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe. The numbers and deployment of care and ancillary staff did not always provide people with a consistent service.

Staff knew how to protect people from being harmed and abused. Appropriate steps were taken to respond to safeguarding concerns.

Arrangements were in place to make sure people received their medicines safely.

Requires improvement

Is the service effective?

The service was not consistently effective. Menus, mealtimes and support with meals needed to be improved to ensure people's nutritional needs were met.

The environment did not fully support the needs of people living with dementia.

Staff were provided with suitable training and support to meet the needs of the people they cared for.

Care and treatment was given with people's consent and the implications of mental capacity law were understood.

People were given support to maintain their health and well-being and to access health care professionals.

Requires improvement

Is the service caring?

The service was caring.

Staff treated people as individuals and were kind and caring in their approach.

People's rights to privacy and dignity were respected.

People were able to make day-to-day choices and decisions about their care.

Good

Is the service responsive?

The service was not consistently responsive. Activities were not routinely provided to help people meet their social needs.

People had individualised care plans that centred on their needs and well-being.

Prompt action was taken to attempt to resolve any complaints about the service.

Requires improvement

Is the service well-led?

The service was well-led.

An experienced registered manager was in post.

Good

Summary of findings

Management were supportive and took on board the views of people using the service, their representatives, and staff.

The quality of the service was monitored to identify where improvements were required.

Hadrian 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 3 and 5 November 2015 and was unannounced. The inspection team consisted of one adult social care inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted the local authority that commissions the service who told us there had been some safeguarding concerns and a concern around staffing levels at the home.

During the inspection we talked with 20 people living at the home and 18 relatives or visitors. We spoke with the registered manager, the regional director, the deputy manager, with 16 care and ancillary staff, and a visiting professional. We observed how staff interacted with and supported people, including during a mealtime. We looked at nine people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People and their relatives expressed no concerns about safety at the home or how people were treated. One relative told us, "I have never seen anything to worry me." Another said, "We have no worries at all, everything is spot on."

Relatives expressed concerns over the levels of staffing on three of the four floors in the home. Visiting relatives with family members on the second and fourth floors said, "We are happy, mostly. There have been a few niggles; my (relative) is on the fourth floor and that floor seems quite short of staff sometimes, though that has improved lately. But down here (second floor) it's still a bit pushed, I think, you can walk in and see no one." A second relative told us, "It's the fourth floor that worries us, it's just not as it should be." A relative of a person on another floor said, "When my (relative) came in, we were told there would always be two staff on down here but now there is only one." Other relatives' comments included, "Well, it could be better. The staff are a bit pushed, sometimes"; "There seems to be enough staff when I am in, though they are a bit busy sometimes"; and, "My only niggle is there doesn't seem to be quite enough staff, they are always busy."

The care staffing levels were determined using an analysis of the numbers of people living at the home and their dependency assessment scorings. On average there were 10 care staff including seniors on duty across the day and seven at night. The registered manager and a proportion of the deputy manager's hours were in addition to these levels. The registered manager felt there was sufficient staff to meet people's needs and capacity within the staff team to cover absence. External agency staff were covering some night duties whilst new staff were being recruited, and, wherever possible, the same agency worker was arranged for consistency. The registered manager, deputy and team leaders operated an on-call system to enable staff to get support at any time from management and, where necessary, to escalate emergencies.

During our visits we observed that staff were visible over the four floors, though some were constantly busy. We did not directly observe any instances when people's care was unsafe and call bells were answered within a reasonable time when people summoned assistance. However, at peak times such as mealtimes we saw that practices were not well organised, leading to delays in food being served to people and, at times, a lack of timely support. On the first day of our inspection, seniors on two floors administered medicines during lunch and did not lead by example by focusing on supporting people with their meals. On our second day, lunch was delayed by a considerable period of time as the cook had not attended. A cook from another home was drafted in to provide cover, arriving later in the morning. However, no other staff had been rostered to work in the kitchen that day and one of the domestic staff was taken away from their duties to help out. We concluded that the numbers and deployment of staff had some negative impact on the service people received and did not always support the smooth running of the home.

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

A recruitment process was followed to check the suitability of new staff. We checked a sample of records for the latest staff recruited. Application forms, with details of employment history and training had been completed before candidates were interviewed. Proof of identity, criminal records checks, and two references, including one from the last employer, were obtained. This showed us that new staff were properly checked and vetted before they were employed.

The staff we spoke with all had a very clear understanding of safeguarding and the need to keep people in their care safe. Any incidents or accidents were recorded and reported. We noted there had been a significant number of incidents involving potentially harmful behaviour between people with dementia-related conditions. The registered manager told us they took incidents into account when allocating the numbers of staff to work on the unit to ensure closer observation and supervision. Action had also been taken to involve a specialist challenging behaviour team and one person, who had been involved in many of the incidents, had subsequently moved onto nursing care in another service. The incidents had reduced as the unit's dynamics had changed and staff reported it was evident that people's relationships had improved.

New staff were given copies of the safeguarding and whistle-blowing (exposing poor practice) policies and all staff were able to access the provider's policies electronically. Safeguarding training was provided annually to refresh staff's knowledge of the different types of abuse that can occur and the procedure to be followed to report

any concerns. A policy had been introduced on the 'duty of candour'. This duty requires registered people to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

We checked the systems for handling people's personal finances. The registered manager told us two people had local authority appointeeship arrangements for their finances. They said they were currently attempting to establish where relatives or other representatives had legal status, such as power of attorney, for managing finances. Many people had chosen to have money for personal spending held for safekeeping at the home. Individual records were kept of transactions undertaken along with receipts for purchases. The entries were suitably recorded but were not being countersigned by a witness and only intermittent audits had been carried out. The regional manager gave us assurance that all future entries would be countersigned and they would personally be carrying out audits of the finances.

Each person had risk assessments in place. A range of generic and specific assessments were used. These covered areas such as dependency, skin integrity, malnutrition, mental health, manual handling and medicines. Once the baseline information had been obtained this was incorporated into the person's care plans. If a person had an individual need outside of the generic risks, for example smoking or using a particular piece of equipment, then this was risk assessed separately and included in the person's care plan. The risk assessments stated the potential problems staff may encounter and what actions staff were required to take, to minimise risk of harm.

There were suitable arrangements for maintaining the environment. Servicing agreements were in place to ensure the safety of facilities and equipment in the home. There were business continuity plans in the event of failure of facilities and the home needing to be evacuated. We were told these would be escalated to and co-ordinated by senior management and had worked well in practice when there had been a short term electrical failure. Each person had a personal evacuation plan in place. This was important because the care environment was set out on four different floors, which could be confusing, and those people with cognitive impairments would be unable to evacuate the building without support and assistance. All stairwells, doors and the lift had keypads to ensure people's safety. These were released if the fire alarm was activated, to allow free movement. At the beginning of our inspection the fire alarms sounded and it was discovered they had been set off by smoke from a toaster. We observed that staff responded appropriately and kept staff on other floors informed about the situation.

The first three floors of the home were clean and odourless. The top floor had marked carpets and soiled areas. We saw staff used appropriate aprons and gloves as needed. Policies and procedures were in place for safe working practices.

Staff told us they had all the necessary equipment to provide safe care for residents, including hoists, sensor mats and bed sensors and pressure relieving mattresses. All staff had been trained in moving and handling theory and practice. We observed staff moved people safely with hoists and standing aids, giving clear, repeated prompts. Specialist equipment was provided at times by the district nursing service.

Accidents were appropriately recorded and followed up by the registered manager. Examples of action taken included referral to a specialist falls team for intervention, reviewing and putting in place aids and equipment, and staff carrying out extra checks on people. All accidents were analysed monthly to look for any themes or patterns. The regional director also checked accidents and incidents and any of higher significance were reviewed by the company's clinical governance team.

We looked at the home's medicines arrangements. Each person had information on their care record to ensure safe administration and guard against medicines being given to the wrong person. This included the person's room number, their date of birth and their photograph. Information regarding any allergies was also recorded, along with contact details for the person's GP. Any special requirements and a description of how the person liked to take their medicines was stated.

Treatment rooms used to store medicines were kept locked, with the keys held by the senior care worker in charge of each floor. The treatment room on floor four had been refurbished. Cupboards were lockable, clean and orderly. The temperatures of fridges used to store

Requires improvement

Is the service safe?

medicines were recorded. Guidelines on the safe storage of controlled drugs (medicines open to misuse) were followed. Appropriate arrangements were in place for the safe disposal of unwanted medicines.

Medicine Administration records (MARs) were generally well managed. Any medicines that were prescribed as 'when required' had laminated information that included the dose, when to give them and any potential side effects. The MARs we checked were all filled in correctly with the relevant codes. They were clear and not open to misinterpretation. Any medicines that had not been given were supported by comments on the reverse side of the MAR sheet, as policy guidelines dictated. Records were kept of the positioning of transdermal patches to ensure these were applied appropriately. We noted some records of topical medicines application were not consistently completed and raised this with management to follow up.

Staff members who administered medicines had been trained and had their competency to administer medicines assessed. A senior care worker told us they always tried to reconcile medicines, such as when a person had returned to the home following a hospital stay. They said they contacted GP's and the pharmacy to confirm the home had correct information about current medicines taken and sufficient supplies. Medicines audits were also routinely completed which identified and acted on any discrepancies and monitored that people were receiving their medicines safely.

Requires improvement

Is the service effective?

Our findings

Relatives told us they felt their loved ones were effectively cared for. One relative said, "It's a grand place." Another relative commented, "It's always so calm and well organised."

We saw staff displayed good skills in working with distressed people. We observed an incident where a person became very agitated and angry. Staff distracted the person gently, listened to the person's story and offered explanations. This interaction went on for over half an hour. Staff took it in turns to soothe and watch the person, and to reassure the other people on the unit who had become upset by the person's agitation. At lunch, staff were able to distract the person to eat and they remained calm for the rest of the day. Staff said "We just keep everything as calm as we can and it passes."

Staff told us that should a person display distressed behaviours they used specific recording charts to identify any causes or triggers. This information helped staff to draw up appropriate care plans to address individual needs. Where this was not effective, assistance from the challenging behaviour team was sought. The registered manager told us they had recognised that new admissions could adversely affect people living with dementia and they planned staffing accordingly.

In some parts of the building attempts had been made to create a dementia-friendly environment. Floor two had developed some themed walls which were great points of interest for people but this needed further development. Floor four did not have any themed areas nor was it a dementia-friendly environment. Staff were aware of this and had requested resources to address this. They clearly recognised how this would benefit people in the early stages of living with a dementia related condition.

The registered manager told us new staff were now undertaking the Care Certificate and team leaders were being trained as assessors. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. Inductions were thorough, with new care assistants working supernumerary to the roster for their first two weeks. Senior carers told us they felt the robust induction which new staff received gave them a good practical knowledge from which to progress, and appeared to have reduced dropout rates.

Staff told us they had appropriate, on-going training, comprising of e-learning and face to face training. They said recent training had included safeguarding vulnerable adults, basic life support, diabetes, oral care and customer care. An overview of the training undertaken by staff was not able to be provided, though was sent on following the inspection. This showed that the majority of staff had completed training deemed mandatory by the provider, including fire safety, moving and handling, food safety and infection control. Other topics of training provided included dementia awareness, health and safety, care planning, caring for people with diabetes and the implications of mental capacity law.

Staff were given opportunities to study for nationally recognised care qualifications. We were told the registered manager and both team leaders were studying towards level 5 diplomas in care leadership and management, and the deputy was enrolling on this course.

There was a delegated system for providing staff with individual supervision every six to eight weeks and annual appraisals. A schedule was in place and this showed that supervisions were given at the planned frequency. The registered manager told us they were considering introducing individual supervision agreements. Supervisions at times included observations of care practice and each session incorporated the provider's 'policy of the month' to keep staff updated. Staff confirmed they received regular supervision and told us the registered manager, deputy and senior staff provided them with good support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and

treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw people who had a cognitive impairment and were unable to give informed consent to residing in the home had been referred to the local authority for a DoLS. The DoLS applications were informative, up-to-date and had a corresponding mental capacity assessment. A central file for DoLS applications was co-ordinated by the deputy manager with details and dates held on computer. Mental capacity assessments had also been carried out which had resulted in best interest decisions around aspects of people's care including support with personal care and medicines and eating and drinking.

Most people told us they were happy with the quality of their meals. Comments included, "The food is okay. We get a cooked meal lunchtime and sometimes we get a choice, then its soup or a salad at teatime"; "We get a choice of meals. The cook is quite good, they make little surprises sometimes"; and, "I've put on weight since I came here, so something must be working." Relatives agreed, saying, "(My relative) eats well"; "The food is getting better. There is a new cook - it had gone down a bit but I think it is coming back up to standard."

Care records showed that nutritional risks were assessed and people had care plans for meeting their dietary needs. Weights were monitored and advice was sought from dieticians and speech and language therapists where risks, such as unexpected weight loss or swallowing difficulties, were identified. Special diets were catered for, including sugar free and pureed meals. Where food was pureed we saw each item was presented separately on the plate. We noted there were jugs of water and juice around the home, but no fruit or snacks.

We observed the lunchtime meal being served. On the second floor dining tables were set with tablecloths, napkins, cutlery, and condiments. People were brought into the dining room from 12.50pm, but lunch was served at 1.25pm. Some people got up and wandered away during the prolonged service time and had to be persuaded back. The meal choice offered was sausage, chips and peas or steak, chips and peas. The meal looked unappetising and rather dry; gravy was offered later but seemed to be cool. A comment heard from one person was, "These chips look awful. This dinner is cold." Another person asked for some other sort of potato or vegetable and was told by a staff member, "Sorry, it's just chips today, nothing else."

Staff offered help to cut up meals or sat beside those needing help. One person sitting slumped in a wheelchair had the offer of the food cut up for them and was then left to try to eat alone, with staff pausing from time to time to encourage them to eat. Only at the end of the meal did a member of staff sit with them to attempt to assist in finishing the meal. This was now cold and the person refused to eat. The staff then brought pudding, of which a little was eaten.

The meal service was disorganised; tea was served whilst people were still drinking their juice. The dining room was cramped. One person had to move their chair so the care assistant could open the fridge door and this broke their concentration on their meal. The medicine round began during the end of the meal. People with difficulties in locating or identifying the right cutlery were not spotted by staff. There was no adapted cutlery, plates or cups in use. For some people such aids may have been useful and allowed them to eat and drink more effectively.

At lunchtime on the ground floor it again took some considerable time before food was served to people in the dining room, lounge and bedrooms. One care assistant spent time providing both hot and cold drinks before helping to serve the meal. Time was taken on asking each person what they wanted and we were told the system for obtaining menu choices in advance was no longer used. Some people in the dining room used adapted cutlery and no-one needed direct assistance with eating and drinking. There were empty teapots and milk jugs on the tables and napkins were available but not given to people to use. Staff prompted and encouraged people to eat and offered extra portions.

A three week menu cycle with choices of meals was in place. However, we found the meals being provided often did not match with the menus, some foods on the menus were not in stock, and at times there was repetition. For example, the cook told us there was no beef and this was being substituted by sausages for tea on the second day of our inspection. The same pudding, sponge and custard, had been served on Tuesday and Thursday, though this was not on the menu for either day. The cook told us there was not enough bananas available to serve them with

Requires improvement

Is the service effective?

custard for pudding. No menus were displayed and the people and staff we talked with were not aware of what meals were being provided on the day. We concluded that people could not always be assured of receiving a varied diet with food at the optimum temperature, and, where needed, support and prompts with eating.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most relatives described good communication with staff. One said, "They call us if anything is wrong." A second relative told us, "I haven't a bad word to say about the place, they ring us if anything is amiss." Another relative said, "They rang us when (my relative) had a chest infection and the staff went with them to hospital." We followed up specific health-related issues raised by two relatives and found their family members had capacity to make their own decisions about complying with their care and treatment.

There was evidence in care records of seeking advice from health care professionals including district nurses, community mental health staff, GP's and consultant psychiatrists. These visits were recorded and advice was incorporated into care plans. Care plans identified the person's previous medical conditions and any allergies. Any future decisions made by the person, such as instructions not to be resuscitated and emergency health care plans, were recorded clearly.

The district nurse lead for the home told us they felt working relationships had greatly improved. They said the district nurses received appropriate referrals from the service and that staff were good at following their guidance. The nurses co-ordinated their work with the surgery that most people used, who did a weekly GP round at the home. On occasions, people were also referred to an older person's specialist nurse for advice and treatment.

We recommend that the service considers current best practice to enhance the environment in relation to the needs of people living with dementia.

Good

Is the service caring?

Our findings

People told us that the staff were kind and attentive. One person said, "The girls look after us very well." Another said, "It's very nice here, the girls look after me." A third person told us, "The girls are nice to me." This person's relative said, "On the whole the care is good, the girls are nice, they ring me if there is anything." A second relative commented, "The girls are very nice and do their best, they always greet us when we come in." A third relative told us,"My (relative) is well looked after."

Relatives were also complimentary about the caring nature of the staff team. One relative told us, "The staff are wonderful, very caring. They will do anything for you." Another commented, "It's absolutely brilliant, here, my (relative) is so well looked after. The staff have been brilliant with (relative) and they have improved since coming here." We were told there were no restrictions on visiting and relatives said they were always made welcome. One said, "They are really nice to us when we come in, they ask us if we want a cuppa, we couldn't ask for better."

Our observations of staff going about their daily working routines indicated they were always polite and had a very caring attitude towards people. This was reflected in the way they spoke with people and how they took time with people, not rushing them and treating them with respect and dignity. Staff explained to people what they were doing and why. They responded to people's questions, directing them around the units to bedrooms, bathroom or the toilet, and gave support and assistance when it was required.

All the staff we talked with were very knowledgeable about people's needs and preferences and the best approach to take when giving individual's care and support. During a group discussion with three care staff they told us about their strong beliefs in using tactile communication with people, where this was appropriate, and how well people responded to this. The staff also said they had benefitted from practical and role-play training, such as during a moving and handling course, and how this had helped them understand people's care experiences.

Several people living with dementia found it difficult to concentrate during lunch and one person constantly got up and left the table. We saw this was managed in a very positive and sensitive way, with staff quietly going up to the person, explaining that it was lunch time and encouraging the person to finish their meal and escorting them back into the dining room. We saw one care assistant stopped to talk to a person who had been outside, and said, "Your hands are cold, come with me and we'll get you warmed up." Domestic staff were all very polite and industrious and spent time interacting very well with people as they went about their work. The atmosphere was relaxed and cheerful. During the afternoon music was being played and people were responding very well to this. On the second day of our visit, we saw staff kept people entertained and apologised to them about the delay in lunch being served.

We observed that when staff were assisting people with transfers and using wheelchairs, they followed best practice and maintained dignity throughout the procedures. Care staff we spoke with were mindful of preserving people's dignity. For instance, they told us they supported a person with a sensory impairment to go to and from the toilet, but did not stay with them whilst they used the toilet. We saw many occasions when staff reassured people and at all times they were respectful in their approach. Most people we spoke with said staff worked hard to maintain people's dignity. One relative said, "It's great, she is so well looked after, the girls are really good, they try hard to keep her nice and clean." A minority of visitors we spoke with had concerns about the laundry and felt their friends/relatives were sometimes not well turned out.

The service used a computerised system for care plans. Computer stations and filing cabinets were in the corner of the lounges. This meant that there was no privacy when staff were discussing people or any aspect of their care, and it was possible to see people's personal details on the computer. This was a potential breach of confidentiality that we raised with the management with a request to resolve this issue.

We saw people were given some information about what to expect from living at the home, such as an informative guide to the service. Information displayed in the reception area included newsletters, company publications and forms to give feedback about the service. We were told feedback was also obtained through 'resident and relative' meetings and periodic surveys. However, although there was a noticeboard for feedback, the information on display was from 2014. Other noticeboards/display areas specifically for menus and activities were blank and a file

Good

Is the service caring?

with photographs of social events had not been updated since May 2015. This meant there was little information for people and their visitors to refer to, and to check whether their feedback influenced the service.

Requires improvement

Is the service responsive?

Our findings

People told us staff were responsive to their needs. A typical comment was, "They come quickly if you use the buzzer, they are very nice." Most relatives we spoke with said they were happy with the care their relative received and were kept up to date with any changes.

We saw staff regularly visited people who were spending time in their rooms to ensure that their care needs were being met. One person who had spent the morning sleeping was asked if they would like a breakfast or lunch and whether they wanted to eat in their room or in the dining room. A second person did not want either of the lunch menu choices. Staff then gave them other options and made them the toast and coffee that they asked for.

However, some relatives told us the service was not always responsive to people's needs. They gave us examples about the time being taken to obtain appropriate continence pads and attention to detail about one person's personal grooming.

The service used a pre-admission assessment document designed to obtain a wide range of information. This allowed staff to provide a very individual care plan for the person. During our visit we saw a team leader had been to a hospital to assess a person with a view to admission. The registered manager reviewed the assessment; confirmed their needs could be met; and discussed which floor of the home the person could be accommodated on to best suit their needs. Each person had seven mandatory care plans that had to be completed within 24-48 hours from admission and then more individualised plans were developed depending on the person's needs.

A number of assessments were routinely updated to identify people's currents needs. These covered areas such as moving and handling, nutrition, continence, skin integrity, and dependency. The care plans informed staff of people's individual preferences, likes and dislikes. For example, we saw a person had a detailed and personalised plan for meeting their personal care needs. This specified what they were able to do independently, the jewellery they liked to wear, and regular visits to the hairdresser. Another person's plans showed clearly how their cognitive impairment and physical frailty impacted on their care and the additional support that staff would provide.

We saw evidence that care plans were evaluated and care was adapted to meet changing needs or advice from external professionals. Care plans were audited regularly, including by the regional manager. Care reviews were held on a six monthly basis to consult with people and their families and obtain their agreement to the care provided.

A relative told us, "I was fully consulted about the care plan and there has been a review. They gave me (my relative)'s records to look at and check, so I do know that's alright." Other relatives agreed, with comments such as, "We had full care plan involvement, we are fully informed about everything"; and, "We have been involved in all the care plans and things. We couldn't ask for better."

Person-centred care planning was evidenced within the care plans and the deputy manager told us this was being further developed. 'This is me' profiles were evident in some of the records we viewed, which gave staff an overview of what was important to the person, their routines and the ways they preferred to be supported. Some life story work had also been undertaken to give staff better understanding of people's backgrounds and lifestyles.

We noted the service used a computerised system for care planning, which all staff could access, and kept paper copies for reference. However, these paper records were not up to date which gave concerns that, should the system be down for any reason, staff would not have the most up to date information.

Handovers between shift changes were recorded and given verbally, including significant information about people's welfare and any visits from other professionals. This ensured that staff were kept up to date and made aware of any changes or incidents affecting people's well-being.

People told us there were limited social activities or other social stimulation. One person told us, "There's not much in the way of activities now, no one knits or bakes anything anymore, it's a bit dull." A second person said, "We don't do so much now, though there was a singer the other week, some can't do much now." Relatives agreed, with comments such as, "We come and take (relative) out, there is not much to do at the moment"; and, "There is nothing much to do either, reminiscence therapy is so important and dementia friendly things. There are no signs on the (third floor) doors and (relative) can get lost, there just isn't much going on." A visitor said, "I don't think my friend has

Requires improvement

Is the service responsive?

been out since they came in. My friend has a wheelchair and the shop's just down the road, I would ask to take them myself but the staff don't encourage you to ask them things. The television is broken, there is no stimulation, my friend never goes into the lounge and no one encourages them." We observed one person asking a care assistant, "What's to do today?": the staff member replied, "Nothing today."

We observed on all three upper floors how much people enjoyed the big windows overlooking the busy town below. Many spent a long time 'people watching' the scene below. There was a pleasant, safe enclosed garden with seats and raised flower beds, with the walls painted by the local college.

The staff we talked with had a clear understanding of people's needs, likes and preferences. They told us they felt the level of care they gave could be improved if there was more time to provide social activities. At the time of our inspection the home had just appointed a new activities co-ordinator who was due to take up post in the near future. The registered manager told us there had previously been a monthly programme of activities and events and that staff had provided some ad-hoc activities in the time since the last co-ordinator left. They acknowledged that there was no evidence of activities being advertised in the home and agreed that activities needed to be better structured until the new co-ordinator started.

The home had a complaints procedure that people and their representatives could use if they had any concerns about their care or the service. Three complaints had been made in the last year, two of which were about missing items. The third complaint related to a care issue and had been referred to the local safeguarding authority and closed. Meetings had been held with the complainants and the complaint had been escalated to senior management for resolution. This showed us that complaints were taken seriously and properly addressed.

We recommend the provider provides social stimulation on a daily basis to meet the social needs of people living at the home.

Good

Is the service well-led?

Our findings

The service had an experienced registered manager who had been in post at the home since 2014. They were fully aware of the requirements of their registration and had notified the Care Quality Commission (CQC) of events that had occurred at the service.

The registered manager was supported in their role by a deputy manager, senior staff and regular contact with the service's regional director. The senior staff team had been strengthened with the introduction of two team leaders and a three month programme of training for the senior team specific to their roles and responsibilities. A team leader and a care assistant confirmed that the new structure worked well and the team leader told us, "We audit one another's work."

The staff we talked with told us they were very well supported. They had confidence in the senior staff and felt able to discuss any problems or concerns that they might have. Staff said they were kept well informed through regular staff meetings, supervisions and annual appraisals. We saw monthly staff meetings and separate meetings for senior staff were held. There was a good level of debate around care practices, people's rights and choices, and staff training at the meetings. Discussion about staff keeping up to date with memorandums and the provider's 'policy of the month' were also included. Recent policy topics had included whistle-blowing, eating well in older age, accident and incident reporting, care planning and fire safety.

Staff told us the regional director visited the home frequently and always spent time talking to members of staff, people and their visitors. The provider also had a counselling support line which all staff were able to access.

Visitors we spoke with said they had lots of confidence in the staff but wished the problem with the lack of social activities would be resolved soon. A relative said, "A lot of staff have been here a long time and the manager is quite dynamic, you see her about all the time, I think it makes a difference."

'Resident and relative' meetings had been reinstated and were being chaired by the registered manager. The meeting minutes showed each item on the agenda was now set out with actions to be taken in response to feedback and suggestions.

Surveys had been undertaken with people and their families by a market research organisation and the 2015 results were expected to be publicised in the near future. The registered manager told us they would be acting on any areas of the service identified for improvement. They provided us with the findings of an internal satisfaction survey carried out with relatives earlier this year and the actions they had taken in response. These were set out in a 'You said, we did' format and included further training for staff, the appointment of a new activities co-ordinator and developing a recruitment test for new staff.

The registered manager carried out checks on staff performance including during the night and at weekends to ensure people were being properly cared for. They said they would not tolerate poor care and had, when necessary, taken disciplinary action with staff where conduct issues were identified. They had also on occasions informed agencies who supplied care staff of when they no longer wanted particular staff to work at the home again.

We saw the registered manager completed monthly reports which appraised the regional director of significant information about the service and people's care. The reports detailed any incidence of pressure ulcers, choking, infections, hospital admissions and deaths. Safety issues such as any medicines errors and safeguarding alerts were also included to enable the regional director to check appropriate action had been taken.

A range of internal audits were conducted to check the quality of the service. These covered areas such as health and safety, care planning and medicines management. The regional director carried out comprehensive quality reviews which were aligned to the care standards set by CQC. The findings of all checks and audits fed into a 'service improvement plan' (SIP) which highlighted those aspects of the service that needed to be developed and timescales for remedial action. The SIP's were sent on to the provider's operations director and governance team for scrutiny and follow up. The regional director and registered manager told us their vision for the service was to meet all areas of the SIP and develop a more customer focused approach to the service.

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 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person had not ensured that nutritional needs of people using the service were met.** Regulation 14 (4)(a)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the needs of people using the service.** Regulation 18 (1)