Lowfield House Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an inspection of Lowfield house Limited on 23 and 25 April 2018. The first day was unannounced.

Lowfield house Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Lowfield house Limited is located in the centre of Clitheroe in Lancashire. The service is registered to provide accommodation and personal care for up to 24 people. The service does not provide nursing care. There were 20 people accommodated at the time of the inspection. Accommodation is provided over two floors linked by a passenger lift. All bedrooms are single occupancy and 21 have ensuite facilities.

At the previous inspection on 2 and 3 October 2017, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the recruitment of new staff, staff training, the implementation of the Mental Capacity Act 2005, maintenance of the property and a continuing breach in relation to the governance arrangements. We also made a recommendation about ensuring people's care plans fully reflected their personal preferences and the care they were receiving. Following the inspection, we asked the provider to take action to make improvements and to send us an action plan.

During this inspection, we found there had been improvements made to the recruitment policies and procedures, the provision of staff training, maintenance and servicing of the property and to the governance arrangements. We found improvements to risk and incident management, medicines management and care planning were ongoing.

The service was managed by 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.

People told us they felt safe in the home and they were very happy with the service they received. People appeared comfortable in the company of staff. Safeguarding adults' procedures were in place and staff understood how to protect people from abuse. Staff treated people in a respectful and dignified manner and people's privacy was respected.

There were systems in place to manage people's medicines although additional improvements to the systems were needed. Staff administering medicines had been trained and supervised to do this safely.

Risks associated with the environment and with people's health and welfare had been assessed. There was a system in place to record accidents and incidents. However, the registered manager was aware further

action was needed in order to monitor people's skin integrity and to identify any patterns and trends associated with accidents.

Quality assurance and auditing processes had been improved to help the provider and the registered manager to identify and respond to matters needing attention. The systems to obtain the views of people, their visitors and staff had also been improved.

A safe and robust recruitment procedure was in place to ensure new staff would be suitable to care for vulnerable people. Arrangements were in place to make sure staff were trained and competent. People considered there were enough staff to support them when they needed any help.

Appropriate Deprivation of Liberty Safeguard (DoLS) applications had been made to the local authority and people's mental capacity to make their own decisions had been assessed. However, additional information was needed to ensure people's preferences were met.

People had access to a number of activities inside the home and were supported to maintain relationships with friends and family. There were no restrictions placed on visiting times for friends and relatives. People told us they enjoyed the meals and their dietary preferences were met. We observed meal times were a relaxed experience. People had access to a GP and other health care professionals when they needed them.

People told us they were happy and did not have any complaints about the service they received. They knew how to raise their concerns and complaints and were confident they would be listened to.

There had been an improvement in the records relating to people's care and support and people's preferences and routines were being recorded. However, the registered manager was aware further improvements were needed to ensure staff were provided with clear guidance.

The home was clean and bright and appropriate aids and adaptations had been provided to help maintain people's safety, independence and comfort. There were checks in place to ensure systems and equipment were safe and serviced.

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 consistently safe.

Risks to the health, safety and wellbeing of people who used the service were being assessed; further improvements were being made to ensure assessments were in line with current recognised guidance.

Accident and incident monitoring had improved to ensure people's safety. Further analysis was needed to ensure appropriate action was taken to keep people safe.

People felt safe in the home and were protected against the risk of abuse. All areas of the home seen were clean.

There were sufficient staff to meet people's care and support needs. Policies and procedures were in place to ensure the provider operated an effective recruitment procedure.

People's medicines were administered by trained and competent staff but further improvements were needed.

Is the service effective?

Good

The service was effective.

Staff were provided with training, supervision and support.

People enjoyed the meals and choices were offered. People were supported to maintain good health.

Staff had received training to improve their understanding of the MCA 2005 legislation. The records relating to people's capacity to make safe decisions and to consent to care had improved and were being improved further to ensure assessments were decision specific.

Is the service caring?

Good

The service was caring.

People told us the staff treated them with care and kindness. We

observed good relationships between staff and people living in the home.

People were encouraged to maintain relationships with family and friends. There were no restrictions placed on visiting.

Staff respected people's rights to privacy, dignity and independence. Where possible, people were able to make their own choices and were involved in decisions about their day.

Is the service responsive?

Good

The service was responsive.

People had access to a range of suitable activities which were arranged on an informal basis based on people's preferences.

The information in people's care plans had improved and further improvements were being made to ensure they included detail about people's personal preferences.

People had no complaints and felt confident raising their concerns and complaints with the management team or with staff.

Is the service well-led?

Good

The service was well led.

People had confidence in the management of the home.

The systems to obtain people's views and opinions had improved.

The systems to assess and monitor the quality of the service in all aspects of the management had improved and were being further developed.

Lowfield house Limited

Detailed findings

Background to this inspection

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

We visited Lowfield house Limited on 23 and 25 April 2018. The first day was unannounced. The inspection was carried out by one adult social care inspector.

In preparation for our visit, we contacted the local authority contracting unit for feedback and checked the information we held about the service and the provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with six people living in the home and with three visitors. We also spoke with the registered manager, the deputy manager, three care staff and the owner (nominated individual) of Lowfield house Limited.

We looked at a sample of records including five people's care plans and other associated documentation, staff rotas, training and supervision records, minutes from meetings, medicines administration records, policies and procedures, service certificates and quality assurance records. We also looked at the most recent report from the local authority infection prevention and control lead nurse, the fire safety report and the report from the local authority contracts monitoring team.

Following the inspection visit we spoke with a fire safety officer and with a healthcare professional who visited the home. We also asked the provider to confirm that all recommendations made following the fire safety officer's visit had been completed. The provider sent us the information as requested.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of 2 and 3 October 2017 we found the provider had failed to properly maintain the property. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found safety systems had not been tested in a timely manner and therefore people were exposed to potential risks to their health and safety. Following the inspection the owner made immediate arrangements to ensure all systems were safe and serviced and sent us copies of the certificates and an action plan.

During this inspection we found improvements had been made. We found documentation was in place to demonstrate regular health and safety checks had been carried out on all aspects of the environment. We saw equipment was safe and had been serviced at regular intervals. During the inspection we noted a fire exit was obstructed and electrical equipment was being charged and stored on the corridor. This could present a risk to people's safety. The registered manager immediately addressed this. We noted there had been no recommendations made following a visit from a fire safety officer in January 2017.

Following the inspection visit we asked the local authority fire safety officer for advice regarding the fire system and safe exit from the building in the event of a fire. The fire safety officer visited the service and recommended that the fire door access codes should be the same number throughout, be clearly visible and be known to staff. They also asked the provider to update the fire risk assessment to reflect this. We spoke with the fire safety advisor; they confirmed the service was safe and no further action was needed once the recommendations were in place. The provider notified us when the agreed actions were completed.

There was a business continuity plan, to respond to any adverse events such as loss of power or severe weather. The environmental health officer had recently awarded the service a five star rating for food safety and hygiene.

At the last inspection of 2 and 3 October 2017 we found the provider had failed to establish and operate an effective recruitment procedure. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found the recruitment and selection policy and procedure did not cover all current regulatory requirements. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made to the policies and procedures. However, there had been no new staff recruited from the last inspection visit; this meant we were unable to check whether a safe recruitment and selection process had been followed. The registered manager was able to describe the safe and robust process that would be followed. We will monitor the effectiveness of the process at the next inspection.

During the inspection we observed people were comfortable in the company of staff and staff interaction with people was kind, friendly and patient. People living in the home told us they did not have any concerns

about the way they were cared for. They told us they felt safe. They said, "I feel safe; staff make sure I am" and "I'm content here. I only have to ask if I need help. I am safer here than anywhere." Visitors told us, "I'm happy that [family member] is safe and looked after here."

Staff had safeguarding vulnerable adult's procedures and whistle blowing (reporting poor practice) procedures to refer to. Safeguarding procedures were displayed in the entrance hall and in the main office. Safeguarding procedures are designed to provide staff with guidance to help them protect adults from abuse and the risk of abuse. Staff had received safeguarding training and a designated safeguarding champion was available in the home; the champion was due to attend the local forum for additional advice and training. The champion provided advice and guidance to other staff in this area.

Staff understood how to protect people from abuse and were clear about the action to take if they witnessed or suspected abusive practice. They were confident the registered manager would act on their concerns. Staff were also aware they could take concerns to organisations outside the service if they felt they were not being dealt with. The registered manager was aware of her responsibility to report issues relating to safeguarding to the local authority and the Care Quality Commission.

We discussed with the registered manager, their responsibilities to monitor any safeguarding concerns and accidents and incidents at the service, to ensure a lessons learned approach.

We looked at how the provider managed risks to people's health and safety. We found potential risks to people's safety and wellbeing had been assessed and recorded. Staff had been provided with guidance on how to manage risks in a consistent manner without restricting people's freedom, choice and independence. The assessment information was based on good practice guidance in areas such as falls, mobility and nutrition and had been kept under regular review. This helped to ensure good outcomes of care and support were achieved.

At the last inspection visit we noted assessments had not been carried out to identify and monitor the risks of people developing pressure ulcers; this meant staff did not have clear guidance on how to manage the risks to people's health and well-being in a safe and consistent manner. During this inspection we found the assessments were being introduced but were not yet embedded into staff practice. We discussed the importance of monitoring people's skin integrity with the registered manager. We were told advice and support would be requested from the district nursing service. We will monitor this at the next inspection.

We looked at records kept in relation to accidents and incidents that had occurred at the service. The records were analysed each month in order to identify the number of incidents. Referrals were made, as appropriate, to the GP, the falls team and the district nursing team; we also observed alarm mats in use for two people who had been identified at risk of falls. However, the records needed to be further analysed to determine whether there were any patterns or trends, such as falls occurring at particular times of day or night, and to determine whether there was any action that could be taken to prevent further occurrences. We discussed this area for further improvement with the registered manager.

Staff had access to a set of equality and diversity policies and procedures. We also noted people's individual needs were considered when care was being provided and some information was recorded as part of the care planning process. This helped to ensure all people had access to the same opportunities and the same fair treatment.

During our visit we observed people's calls for assistance were promptly responded to and staff were attentive to people's needs. People using the service and staff told us there were sufficient numbers of staff

to meet people's needs in a safe way.

We looked at the staffing rotas and found there were three or four care staff on duty during the day plus the management team, three care staff during the evening and two at night. In addition to the care staff, the provider employed cleaning and catering staff; the owner provided maintenance cover. There was a system to provide out of hours support. Any shortfalls due to leave or sickness were covered by existing staff or by the registered manager and deputy manager which ensured people were cared for by staff who knew them.

People were happy with the standards of cleanliness in the home. They said, "It always smells and looks clean" and "The home is very clean and fresh. My bedroom is spotless."

At the last inspection we noted there were no cleaning schedules to demonstrate when areas of the home needed to be cleaned. During this inspection we found all areas to be clean and odour free. Domestic staff were employed and cleaning schedules were in use and fully completed. Staff were provided with protective clothing such as aprons and gloves and we saw these in use during the inspection. Staff hand washing facilities, such as liquid soap and paper towels had been provided. This ensured staff were able to wash their hands before and after delivering care to help prevent the spread of infection. Additional pedal bins were provided during the inspection. There were contractual arrangements for the safe disposal of waste and we noted there was an infection prevention and control policy and procedure.

We noted actions for improvement had been recommended following a visit from the local authority infection prevention and control lead nurse in February 2018; we were told a provider action plan, in response to the report, had not yet been provided. During the inspection the local authority infection prevention and control lead nurse re-sent the report to the registered manager for action. Areas for improvement included providing the infection control lead person with clear responsibilities, development of infection control policies and procedures, provision of appropriate waste bins and colour coded cleaning equipment and the introduction of specific audits to reduce the risk of spread of infection. We will monitor action taken by the provider at the next inspection.

Assessments to identify potential risks in the home associated with fire safety, falls, the control and use of hazardous substances and the control and prevention of infection had been undertaken. Each person had a personal emergency evacuation plan (PEEP) which recorded information about their mobility and responsiveness in the event of a fire alarm. The service had emergency contingency plans to enable people to receive the care and treatment they required should an emergency occur that stopped the service from operating. We discussed developing links with nearby care homes if an evacuation of the home was needed.

Training had been provided to support staff with the safe movement of people. We observed staff using safe practices when supporting people to move around the home. Some staff were trained to deal with healthcare emergencies; further training was planned. Staff had received training in fire safety. Regular fire drills had been recorded and staff knew what action to take in the event of a fire.

We checked two people's personal monies and found the balance was correct. We discussed further improvements to the safety of the systems in use, with the registered manager. These included ensuring clear risk assessments and consent documents were in place for people whose personal allowances were managed by the home, more robust storage and regular balance checks. We also noted not all receipts were available such as for hairdressing and foot care. The registered manager assured us she would action this to ensure the system was safe and robust.

We looked at how the service managed people's medicines. All staff who were responsible for the safe management of people's medicines had received training and checks on their practice had taken place; competency records were being developed to monitor staff practice in more depth. We found a monitored dosage system (MDS) of medicines was being used. This was a storage device designed to simplify the administration of medicines by placing the medicines in separate pods according to the time of day. There were safe processes in place for the receipt, ordering and disposal of medicines.

We looked at eight people's Medication Administration Records (MARs) and found they were clear and accurately completed. We observed people's medicines were given with encouragement, patience and at the correct time. Medicines that were prescribed 'as needed' were supported by clear guidelines and handwritten entries were witnessed to ensure accuracy. There was a system to ensure people's medicines were reviewed by a GP which would help ensure people were receiving the appropriate medicines. Bottled and boxed medicines were dated when opened and there were records to support 'carried forward' amounts from the previous month which helped to monitor whether medicines were being given properly.

We noted there was no information in the care plans about how people preferred to take their medicines and body maps were not used to guide staff with the application of external medicines. We discussed this with the registered manager who proactively took action to rectify these matters and prevent any recurrence. People were identified by a photograph on the MAR which reduced the risk of error. Allergies were recorded clearly in the care plan but not displayed on the MAR. The registered manager was aware the medicine management processes needed to be further developed in accordance with current recognised guidance.

During this inspection, we were unable to check whether appropriate arrangements were in place for the management of controlled medicines which were medicines which may be at risk of misuse.

Visitors were asked to sign in and out of the home which would help keep people secure and safe. The owner told us there was open entry to the home during daytime hours and people would use the doorbell at other times. People and their visitors were aware of the door codes to exit the home.

All staff were bound by contractual arrangements to respect people's confidentiality. We found people's records were stored securely and reviewed regularly to reflect the care they were receiving. Records in relation to the management of the service were maintained and were accurate and kept up to date.

Good

Is the service effective?

Our findings

At the last inspection of 2 and 3 October 2017 we found the provider had failed to act in accordance with the MCA 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found there was limited evidence to demonstrate the relevant requirements of the MCA were being met. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made and further action was being taken to ensure people's preferences and consent were fully considered.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection we checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found staff had an understanding of the purpose and principles of the MCA 2005 and some had received appropriate training. We were told additional training was being sourced. We will review this at the next inspection. Staff also had access to appropriate policies and procedures in relation to the MCA and DoLS.

The registered manager had made appropriate applications to the supervisory body for a DoLS. At the time of the inspection, the registered manager had submitted nine applications to the local authority for consideration. This ensured that people were not unlawfully restricted. We saw the registered manager had a central register of the applications and had checked progress with the local authority on a regular basis.

Staff confirmed they routinely asked for people's consent before providing care and support; this was supported by people's comments and by our observation of staff practices. We noted assessments of people's overall capacity had been recorded which would help to ensure people's rights and freedoms were respected. However, the records needed further review to ensure staff were clear about whether people were able to make specific decisions about particular aspects of their care and support. In addition the records indicating people's consent to care and treatment needed further development in areas such as medicine management, care and the sharing of information. We discussed this with the registered manager and she assured us appropriate action would be taken to ensure people's decisions, abilities and choices were recorded.

We noted one person had a do not attempt cardiopulmonary resuscitation (DNACPR) decision in place. The person's doctor had signed the record and decisions had been taken in consultation with relatives and

relevant health care professionals. A DNACPR decision form in itself is not legally binding. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. The management team were aware that care plans needed to ensure the person's decisions were reflected, kept under review and to ensure all staff were aware of their preferences in relation to this.

At the last inspection of 2 and 3 October 2017 we found the provider had failed to ensure staff had received appropriate training to enable staff to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found there were gaps in the provision of staff training. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made. We found the training matrix was not up to date but this was addressed by the second day of our inspection visit. From our discussions with staff and from looking at records, we found staff received a range of appropriate training to give them the skills and knowledge they needed; additional training was taking place to address any shortfalls. Recent training included moving and handling, medicines management, stoma care and catheter care. We noted staff had not completed recent training with regards to first aid, health and safety and end of life care training. We discussed this with the registered manager who was aware of the gaps and was sourcing appropriate training.

We were unable to review the provision of induction training as there had been no new staff since the last inspection. The registered manager described the arrangements in place to introduce new staff to the home; they included an initial orientation induction, the provider's mandatory training and the Care Certificate. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care.

Records evidenced staff were provided with supervision and support. One to one staff supervision sessions helped identify shortfalls in staff practice and the need for any additional training and support. Staff told us they felt supported by the management team. They told us they were encouraged to express their views and opinions and to receive any updates at regular staff meetings.

We looked around the home and found it to be bright, comfortable and well maintained. Aids and adaptations had been provided to help maintain people's safety, independence and comfort. All of the bedrooms were single occupancy. People, or their visitors, told us they were happy with their bedrooms and some had created a homely environment with personal effects such as furniture, photographs, pictures and ornaments. Bathrooms and toilets were located near to communal areas and were suitably equipped and signed.

Corridors were bright although we noted obstructions in the fire exit area and on the corridor; the registered manager ensured the areas were cleared immediately. Accommodation was on two floors accessed by stair ways or by a passenger lift. We were told the third floor was used only by the provider and staff and that the tumble dryer on that floor was being used by staff as a temporary measure; we noted all areas on the third floor were extremely untidy and cluttered and could present a risk. Following the inspection we asked the provider to clear the area, to ensure all equipment was serviced and safe and to ensure the fire door was closed at all times. The provider confirmed this work had been completed.

People and staff told us they were happy with the improvements to the environment made so far. People commented, "It's a bit tired in places but there has been some improvement", "The home is nice and warm",

and "The décor isn't to my taste but the newly decorated bedrooms are lovely. I understand there are plans to decorate all areas." Whilst there was no formal improvement plan we noted redecoration and refurbishment of the service was ongoing. Bedrooms had been redecorated and refurnished to date and work was ongoing, new lounge armchairs and side tables were provided and a hairdressing salon was now available. Gardens were well maintained with seating and adequate shelter available; a shed and a greenhouse were available for anyone who enjoyed gardening.

During our previous inspection, we found the sound of the call bells in the lounge areas was piercing and uncomfortable. People told us how uncomfortable this was. At that time the registered manager had agreed to investigate further to see if the call bell system could be adjusted. During this inspection we found work was being undertaken to reduce the noise.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals and they could have other choices. They told us, "The food is lovely; just how I like it", "The meals are very good. First class" and "There is a good selection of meals."

During our visit we observed lunch being served in the main dining room and in other areas of the home if people preferred. We observed people enjoyed their meals and alternatives to the menu were provided. The meals looked appetising and the portions varied in amount for each person; people were offered extra helpings.

We observed people being supported and encouraged to eat their meals at their own pace and we overheard friendly conversations during the lunchtime period. The main menu was displayed and people were asked for their choices each day. The dining tables were appropriately set and condiments and drinks were made available. However, we noted chipped tumblers and a stained juice jug were being used; the registered manager immediately replaced them. Protective clothing was provided to maintain people's dignity and independence. We observed drinks and snacks being offered throughout the day and on request.

Information about people's dietary preferences and any risks associated with their nutritional needs was shared with kitchen staff and maintained on people's care plans. We were told records would be made of people's dietary and fluid intake where needed. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

We looked at how people were supported with their healthcare needs. People's care records included information about their medical history. However, more detail was necessary about any needs related to their health and how this impacted on their day to day living, to provide guidance and understanding for staff. Records showed that the nurse practitioner and district nursing team regularly visited the service and monitored the care and treatment of people in their care; appropriate referrals were made to a variety of healthcare agencies. A healthcare professional told us, "Staff are responsive to our requests." A relative considered their family member's health care was managed well.

Information was shared when people moved between services such as transfer to other service, admission to hospital or attendance at health appointments. People were accompanied by a record containing a summary of their essential details and information about their medicines; where possible, a member of staff or a family member would accompany the person. In this way people's needs were known and taken into account and care was provided consistently when moving between services.

Good

Is the service caring?

Our findings

People told us they were treated with care, respect and kindness and they were complimentary of the support they received. They said, "The staff are so caring. They do all they can to make sure I am comfortable" and "The staff are lovely and helpful. They are kind and caring towards me." Visitors told us, "Staff are caring and committed to looking after the needs of the resident" and "I am very happy with [family member]'s care."

Compliments received by the home highlighted the caring approach adopted by staff. People's comments included, "Thank you for your wonderful care", "Thank you for all you do. It's very much appreciated" and "Thank you for being awesome."

Relatives confirmed there were no restrictions placed on visiting and they were made welcome in the home. We observed relatives visiting at various times throughout the two days we were present in the home.

During our visit we observed staff interacting with people in a caring, friendly and respectful manner and we observed appropriate humour and warmth from staff towards people. People appeared comfortable in the company of staff and had developed positive relationships with them. Staff were knowledgeable about people's individual needs and personalities. We observed people being asked for their opinions and consent on various matters and noted they were routinely asked where they wished to sit, what they wanted to eat and how they wished to spend their time.

We observed people were treated with dignity and respect at all times and without discrimination. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. People were encouraged to maintain their independence.

People's wishes and choices with regards to spiritual or religious needs was recorded. They confirmed they were able to attend religious services in the home. However, we noted people's wishes and choices with regards to receiving personal care from female or male carers and people's ethnicity and sexual orientation was not recorded in their care documentation; this meant staff may not be aware of people's diversity or acknowledge people's right to be free from discrimination. The management team told us this information would be considered as part of the pre-admission assessments and care planning going forward.

People were dressed appropriately in suitable clothing of their choice. One person said, "My clothes are always nice and clean; I get them back in good time." We observed staff supporting people in a manner that encouraged them to maintain and build their independence skills. For example, people were supported to maintain their mobility skills. One person told us, "I can do things for myself but staff offer to help me when I need it."

People were encouraged to express their views by means of daily conversations, taking part in satisfaction surveys and during residents' meetings. The residents' meetings helped keep people informed of proposed

events and gave people the opportunity to be consulted and make shared decisions.

People were supported to be comfortable in their surroundings. People told us they were happy with their bedrooms. One person told us they had their room decorated according to their personal colour preferences. Bedrooms were fitted with appropriate locks and people told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter.

Useful information was displayed on the house notice boards and informed people about how to raise their concerns, any planned activities and any changes in the home. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

People were provided with a copy of a welcome pack on admission to the home which provided an overview of the services and facilities available in the home. The registered manager told us the information could be made available in other formats to ensure it was accessible to everyone. Information was also available on the website.

Good

Is the service responsive?

Our findings

People were happy with the personal care and support they received and made positive comments about the staff and about their willingness to help them.

At the last inspection of 2 and 3 October 2017 we recommended the service sought advice and guidance from a reputable source to ensure people's care plans were person centred and reflected the care they were receiving.

During this inspection we found some improvements had been made and additional improvements were underway. Each person had an individual care plan which was underpinned by a series of risk assessments. Useful information about people's likes, dislikes, preferences and routines was gathered during the initial assessment but we found this was not always included in the care plans. This information helped ensure people received personalised care and support in a way they both wanted and needed. However, we observed one page profiles recorded what was important to each person and how they could best be supported. The registered manager told us further work was being done to ensure the care plans provided staff with clear guidance on how best to support people and to be mindful of what was important in their lives when providing their support. The advice given by health care professionals was clearly documented and followed.

People's care and support had been kept under review and records updated on a regular basis. People spoken with said they were kept up to date and involved in decisions about care and support and had been involved in providing useful information about their preferences, interests and routines. Daily reports provided evidence to show the care and support people had received and how they had spent their day; these were written sensitively and respectfully. We also noted records were completed as necessary for people who required aspects of their care monitoring, for example, with personal hygiene and nutrition.

There were systems in place to ensure staff could respond to people's changing needs. They included a handover meeting at the start and end of each shift and the use of communication diaries and notice boards. This ensured staff were kept informed about the care of people living in the home. Staff considered communication was good.

Before a person moved into the home assessments of their physical, mental health and social needs was undertaken by an experienced member of staff. People, or their relatives, would be invited to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff were able to determine whether the home was able to meet their needs.

We looked at how the service managed complaints. People told us they knew who to speak to if they had any concerns or complaints and could raise any concerns with the staff or with the registered manager. People said, "I can tell them anything and it gets sorted" and "They are happy to listen. We can tell them there and then or discuss it in our meetings." A relative commented, "I have no problems at all. All my

concerns are dealt with."

The registered manager told us there had been no complaints made about this service since the last inspection visit. People told us they were able to discuss any minor concerns during resident meetings or at the time they occurred; they told us they were resolved at that time. We noted a record was not maintained of people's concerns; this meant it was difficult to monitor the frequency and theme of people's concerns. We discussed this with the registered manager who assured us a record would be maintained.

The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC). The registered manager was aware the procedure should include that CQC does not investigate complaints and the local authority or local ombudsman had primary responsibility for this. We noted there was a complaints procedure displayed in the entrance of the home and included in the welcome pack.

The service did not have an activities person. Staff confirmed they were responsible for providing activities in between their caring responsibilities. People had mixed views about the provision of activities and entertainments. People told us, "I'm happy to join in; they let me know what is on and I make my decision" and "There is little to do. I watch television, listen to music. There is always someone to have a talk to." A relative told us, "There isn't enough going on but it is difficult to please everyone".

There was a monthly activity list displayed, which provided details of forthcoming events such as bingo, crafts, dominoes and films. Staff told us individual and group activities were arranged on a daily basis according to people's preferences and that entertainers visited the home. On the day of our visit we observed some people singing along to a DVD, people reading books and newspapers and others watching TV in their bedrooms or in the lounges. We were told that people had enjoyed sitting outside in the sunshine the previous weekend, eating ice cream and enjoying singing along with a visiting entertainment group.

People were supported to maintain relationships with friends and family. They were also actively encouraged and supported to maintain local community links and develop new relationships. For example, people visited local shops either with staff or with their visitors, where they could have a drink and a meal and meet other people. We observed one person moving freely in and out of the house. One person told us the hairdresser and podiatrist visited regularly. Representatives from various religious faiths visited the home on a regular basis to enable people to practice their spiritual beliefs.

Some people's choices and wishes for end of life care were being recorded. However, this area needed further development to ensure people's advanced care preferences were recorded and known by staff. The service had developed good links with specialist professionals and there were systems in place to ensure staff had access to appropriate end of life equipment and advice. We were told additional end of life training was planned for this year to support staff development and confidence in this area.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We noted information was displayed on notice boards and some of the information was in larger print. The registered manager confirmed the complaints procedure and service user guide would be made available in different font sizes to help people with visual impairments. We found there was information in people's initial assessments about their communication skills to ensure staff were aware of any specific needs.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted the service had internet access to enhance communication and provide access to relevant information for people using the service, their visitors and staff. This enabled people to have on-line contact with families and friends. E-learning formed part of the staff training and development programme. Alarm mats were used to alert staff when people were at risk of falling and staff were able to access remote clinical consultations which meant prompt professional advice could be accessed at any time.

Good

Is the service well-led?

Our findings

At the last inspection of 2 and 3 October 2017 we found the provider had failed to implement an effective quality assurance system and maintain accurate records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found there were few opportunities for people to provide formal feedback about the quality of the service, records were inaccurate and we noted shortfalls in many aspects the service. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found the systems to assess and monitor the quality of the service had improved and were being further developed. We noted checks had been completed on areas including medicines management, housekeeping, the environment, care planning, accidents and incidents and infection prevention and control. We discussed the need for auditing the existing staff files as there had been some shortfalls noted at the last inspection. The registered manager and deputy manager also worked with staff which helped them to monitor staff practice.

Systems had been introduced to formally consult with people and to ask for their views on the service. This was achieved by daily conversations, meetings and annual satisfaction surveys. A satisfaction questionnaire had been distributed in January 2017. We looked at a sample of the returned questionnaires and noted people were satisfied with the service. However, we noted that whilst the registered manager was aware of the feedback, the results and any action taken had not been shared with people. The registered manager assured us the results would be displayed on the notice board. Resident's meetings had taken place and people had been given the opportunity to share their views, be kept up to date and to have input into the development of the home.

People, relatives and staff spoken with told us they were satisfied with the service provided at the home and the way it was managed. A relative commented, "The home is well run. Everyone is looked after. It is a real family home." Staff said, "We have a good manager. I can talk to her anytime."

There was a manager in post who was registered with the commission. 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.

The registered manager had responsibility for the day to day operation of the service. We noted during the inspection, the registered manager was visible and active within the home and she interacted warmly and professionally with people, relatives and staff. People were relaxed in the company of the registered manager and it was clear she had built good relationships. During the inspection, we spoke with the registered manager about the daily operation of the home. She was able to answer our questions about the care provided to people showing that she had a good overview of people's needs and preferences.

There was a relaxed friendly atmosphere in the home. We observed a good working relationship between

the registered manager and the provider. The registered provider visited the home each day and we were told any issues relating to the day to day running of the home were discussed and appropriate action taken. However, we noted the processes to monitor the registered manager's practice and to monitor the day to day running of the home were not formalised; this meant there was limited evidence to support the provider had oversight of all aspects of the service. This was discussed with the registered manager and with the provider who assured us this would be addressed.

All staff had been provided with job descriptions, contracts of employment and policies and procedures which would make sure they were aware of their role and responsibilities. Staff were aware of who to contact in the event of any emergency or concerns. If the registered manager was not present, there was always a senior member of staff on duty with designated responsibilities. They told us they were kept up to date and encouraged to share their views and opinions at meetings. Staff told us they enjoyed their work. Staff said, "I enjoy working here. Most of the staff have worked here for many years; that says a lot about the place."

Staff meetings had taken place and discussions had been recorded. Records showed they had been able to raise their views, kept up to date with any changes in the home and they were listened to. However, we noted that the areas for discussion had been quite limited and had not covered areas such as fire safety, concerns and staff conduct. In addition, the information from accidents and incidents, audits, concerns and safeguarding alerts were not shared with the staff team to look at lessons and learned. We discussed this with the registered manager who agreed to address this at the next meeting.

We looked at how the service worked in partnership with other agencies. We found arrangements were in place to liaise with other stakeholders including local authorities and commissioners of service. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams.

We noted the service's CQC rating and a copy of the previous inspection report was on display in the home. This was to inform people of the outcome of the last inspection and of any action taken to improve.

The registered provider had achieved the Investors in People award. This is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management.