Hexon Limited

The Willows

Inspection report

Bridlington Road
Burton Fleming
Driffield
Humberside
YO25 3PE

Tel: 01262470217

Date of inspection visit:
26 January 2016

Date of publication:
01 March 2016

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10 June 2015. Two breaches of legal requirements were found. After the comprehensive inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of Regulation 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in respect of insufficient numbers of suitably qualified staff being deployed in order to meet people's assessed needs, and the premises not being suitable for the purpose for which they were being used.

We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements, to look at the overall quality of the service, and to provide a new rating for the service under the Care Act 2014.

The home is registered to provide accommodation for up to 33 people who require assistance with personal care, some of whom may be living with dementia. On the day of the inspection there were 28 people living at the home, including three people who were having respite care. The home is situated in the centre of the village of Burton Fleming, close to the town of Bridlington, in the East Riding of Yorkshire. The general care unit and the dementia care unit are staffed separately.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was not registered with the Care Quality Commission (CQC). However, they had submitted an application for registration and it was being progressed by 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.

During this inspection we identified two breaches of regulation; this related to the risks associated with the submission of notifications to the CQC and safe care and treatment. You can see what action we told registered the provider to take at the back of the full version of the report.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at the home.

Some improvements had been made to the environment. On the first floor of the premises [the dementia unit] an additional seating area had been created so there was space for people to sit quietly if they chose to do so, or to meet with family and friends in private. However, we identified some concerns with the environment such as loose bath sides and a damaged bed and these had not been identified in audits undertaken by the service.

People told us that they felt safe whilst they were living at The Willows. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. Staff also told us that they would not hesitate to use the home's whistle blowing procedure if needed. Although safeguarding alerts had been submitted to the local authority when required, the CQC had not received notifications from the registered provider.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. Staff had received training on the administration of medication and people told us they were happy with how they received their medicines.

People told us that staff were caring and that their privacy and dignity was respected. People told us that they received the support they required from staff and that their care plans were reviewed and updated as required.

People's nutritional needs had been assessed and they told us they were very happy with the food provided.

There was a complaints policy and procedure in place and we saw that any complaints or concerns raised had been dealt with following the home's policies and procedures. However, we noted complaints were stored in both the quality assurance folder and in the 'significant events' folder and this could have made it difficult to monitor complaint received.

There were systems in place to seek feedback from people who received a service, and feedback had been analysed to identify any improvements that needed to be made.

The quality audits undertaken by the registered provider were designed to identify any areas that needed to improve in respect of people's care and welfare. Staff told us that, on occasions, incidents that had occurred had been used as a learning opportunity for staff. However, we found some areas that required improvement that had not been identified through the home's own quality audits. We have made a recommendation about the effectiveness of quality audits in this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Some environmental risks had not been identified by the service and this left people at risk of avoidable harm.

Staff had received training on safeguarding adults from abuse and moving and handling.

There were sufficient numbers of staff employed to meet the needs of people who lived at the home, and staff had been recruited safely.

People were protected against the risks associated with the use and management of medicines.

Is the service effective?

Good

The service was effective.

We found the provider understood how to meet the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

Is the service caring?

Good

The service was caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible.

We saw that people's privacy and dignity was respected by staff

and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and their preferences and wishes for care and support.

Visitors were made welcome at the home and people were encouraged to take part in suitable activities.

People told us that they had no concerns or complaints but they would not hesitate to speak to the registered manager if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not well-led.

Notifications had not always being submitted to the CQC as required.

Quality audits were being carried out but they had not always identified environmental issues that could have placed people at risk of harm.

There was a manager in post and they had submitted an application to the CQC to become the registered manager.

There were sufficient opportunities for people who lived at the home, staff and relatives to express their views about the quality of the service provided.

The Willows

Detailed findings

Background to this inspection

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

The inspection took place on 26 January 2016 and was unannounced. The inspection was carried out by one adult social care inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who has used this type of service. The Expert by Experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the home. The provider was not asked to submit a provider information return (PIR) prior to the inspection. 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.

On the day of the inspection we spoke with four people who lived at the home in depth and chatted to others. We also spoke with four visitors, four members of staff and three community professionals. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the service, including staff training, health and safety and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection on 10 June 2015 we found that there was a breach of Regulation 18 [1]. This was because there were insufficient numbers of staff employed during the day and night to ensure that people who lived at the home received the care and support they needed.

The manager told us that there were five members of care staff on duty each day; this usually included the deputy manager or a senior care worker. There were four care staff on duty from 8.00 am until 8.00 pm, one member of staff on duty from 9.00 am until 5.00 pm, and three staff on duty overnight. We checked the staff rotas for a two week period and saw that these staffing levels had been maintained. In addition to care staff there was a cook and either one or two domestic assistants on duty each day. This meant that care staff were able to concentrate on providing care and support to people who lived at the home.

We experienced first-hand that staff responded quickly when people used the emergency call bell. One person told us, "There is always someone around – I fell and used the call button and three carers came straight away." Two people told us that they thought more staff were needed although they both said this did not impact on their lives as they were fairly independent. Three of the relatives who we spoke with told us they felt there were sufficient numbers of staff on duty, but one relative described a situation when their family member needed assistance with personal care but was told by staff they "Would deal with it later."

Staff told us that staffing levels had improved. One member of staff said, "They [staffing levels] are not bad now – more staff, more time to spend with residents – better atmosphere" and another staff member told us, "Very good now – every day fully staffed – better for staff now." Visiting care professionals told us that there were usually enough staff on duty.

The manager told us that she had received feedback about three staff not being sufficient during the night. She had worked two night shifts so she could monitor this. She said that one person needed to be assisted to change position in bed every 2 hours, and everyone else required a two-hourly check unless they used their emergency call bell in between. The manager felt that three people working during the night could meet the needs of people living at the home. In addition to this, the manager had devised a checklist where the support each person who lived at the home required had been recorded. She used this information to determine how many staffing hours were needed and we saw this was reviewed on a regular basis.

Overall, we found that staffing levels had improved and that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home.

On one occasion on the day of the inspection we saw that there were no staff present in the first floor lounge. We discussed this with the manager and it was acknowledged that this was due to poor planning rather than staff shortages. The manager said that this would be discussed with staff who worked in the dementia unit.

We saw that there was an 'on call' rota that recorded the name of the manager or senior staff member 'on

call' out of normal working hours. This meant that staff were able to contact a more senior member of staff for advice in an emergency.

We asked people if they felt safe living at the home and they confirmed that they did. One person said, "Yes, because there are staff about" and another told us, "Yes, I have the cord and I can pull it and staff come quickly." One person who lived at the home told us that another person sometimes came into their room to ask to use the toilet. We discussed this with staff and the manager and they told us that this was because the rooms were next door to each other and one person sometimes went into the wrong room thinking it was theirs. They told us they would take action to try to prevent this reoccurring and wrote to us following the inspection to inform us that the person who was concerned had decided to have a key to their bedroom door so it could remain locked.

We asked staff how they kept people safe and comments included, "Be there to transfer, keep safe from trips and falls, keep rooms tidy" and "Monitor and assist them – read care plans for all their needs." Relatives told us they felt their family member was safe. One relative told us, "Yes, level of observation is very good – the staff are visible" and "Yes – continuity of staff – staff know [Name]."

Care plans recorded assessments and risk assessments in respect of nutrition, tissue viability, moving and handling, the risk of falls and medication. The mobility risk assessment recorded how many people were needed to assist the person when mobilising and details of any equipment they used. We saw that people also had an environmental risk assessment in place that recorded the safety checks that had taken place in their bedroom to promote their safety. Some people had risk assessments in place for areas that were more specific to them, such as using the conservatory and use of a wheelchair. This showed that any identified risks had been considered and that measures had been put in place to manage them. This included the provision of pressure care equipment when this had been identified as an area of concern.

At the inspection in June 2015 we were concerned about the storage of some products such as bactericide handwash, shaving foam, razors and Steredent. We made a recommendation in respect of this shortfall. During this inspection a care worker showed us where people kept their toiletries; these were kept in a basket in the bottom drawer of their chest of drawers. Most people's bedroom doors were locked but if people did enter someone else's bedroom, these products would not be readily available.

On the day of the inspection we found the home to be cold. We spent some time in the conservatory / dining room and noted there was no heat coming from the radiators. We discussed this with staff and the handyperson and they checked that the boiler was at the correct setting. We noted it was approximately one hour before the radiators heated up. The registered manager told us there were three boilers in different parts of the building and that they had been serviced recently to make sure they were effective. However, we saw that there were a number of oil filled radiators located around the home; these were in the conservatory / dining room, the conservatory and in people's bedrooms. This indicated to us that the heating system was not sufficiently efficient to heat all areas of the home. Although there were risk assessments in place, we discussed how it would be safer not to have freestanding heaters, apart from use in emergency situations. On the day of the inspection we saw the handyperson had provided a cover on the freestanding heater in the conservatory; we had requested this prior to this inspection when we received information of concern from the local authority.

One person had requested that their bedroom door be left open during the day so they could see people 'coming and going'. However, they were concerned about another person who regularly entered their bedroom uninvited. A plastic chain had been placed across the doorway and the manager told us that this had been successful in discouraging this person from entering the bedroom. We were concerned that the

chain could create a hazard that might cause a fall or other injury. We discussed this with the manager who told us the chain was plastic and would come apart if anyone fell against it. They said they would discuss this with the home's handyman and look at information on the Internet to see if a safer solution could be found. Following the day of the inspection the manager wrote to us to tell us that a gate had been provided to replace the use of the chain.

There had been a leak under the floor on the first floor of the home; this was in a corridor outside the toilets. The flooring had to be lifted to carry out a repair, and the joins in the flooring had been 'taped' over to attempt to prevent a trip hazard. The manager told us after the inspection that new flooring had been ordered and was due to be fitted during week commencing 8 February 2016.

One relative pointed out their family member's bed to us. The headboard was very loose and the relative told us it had been loose for some time. We told the manager about this and they informed us the following day that a new bed had been ordered for this person and was due to be delivered on 28 January 2016.

This was a breach of Regulation 12 (2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that care and treatment must be provided in a safe way for service users.

We saw that people had a specific care plan in place in respect of mobility. These recorded any equipment the person needed to use to mobilise safely, and the number of staff that were needed to assist the person with mobility and personal care tasks. The risk assessment in respect of falls was scored to identify the person's level of risk. We saw staff assisting people to mobilise on the day of the inspection and noted that these manoeuvres were carried out safely.

Records we saw showed that staff had completed training on safeguarding adults from abuse. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns to the registered manager. They said they were confident that the registered manager would take appropriate action and ensure issues were dealt with in line with the home's policies and procedures. One member of staff told us, "I would report it to the manager, who would report it to safeguarding and CQC." The manager had introduced a 'significant events' folder. We saw that this included details of any safeguarding incidents, accidents, deaths, complaints and any events that affected the running of the home. One of the events recorded was that the fire alarm was not working; CQC did not receive a notification about this event as required. In addition to this, we saw that two safeguarding incidents had occurred. These had been reported to the local authority appropriately but no notifications had been submitted to CQC, as required. We have made a recommendation about this elsewhere in the report.

Staff told us that they would not hesitate to use the home's whistle blowing policy if needed, and that they were certain their confidentiality would be respected.

We checked the recruitment records for two members of staff. We saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service [DBS]. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw that this information had been received prior to the new employees starting work at the home. This meant that only people considered suitable to work with vulnerable people had been employed. We saw that a record of interview questions and responses had been retained for future reference. Staff were provided with job descriptions; this ensured staff were aware of what was expected of them.

We checked maintenance records and saw that there were up to date service certificates in place for the fire alarm system, fire extinguishers, emergency lighting, gas appliances and boilers, electrical installations and lifts / hoists. In addition to this, in-house checks were being carried out to make sure equipment was properly maintained and safe for use. These included weekly checks on the fire alarm system, profiling beds and mattresses, emergency call bell, wheelchairs, first aid kits and water temperatures. Monthly checks of the fire risk assessment were also carried out. This meant that the premises were being maintained in a safe condition.

We checked the monthly accident audit for December 2015. This recorded one accident and we saw that the relevant details had been recorded and that appropriate medical attention had been sought for the person concerned. The monthly accident audit for the previous month recorded two accidents. Again, the details of the accident had been recorded and there was a record of the action that had been taken. One person had been reminded to use the emergency call bell to request assistance and the other had been advised to see the GP but they had refused this intervention. However, the GP had been informed about the person's fall. We saw that some care plans included body maps that recorded any injuries to the person; this helped staff to manage the person's recovery. We saw that the registered manager checked every accident form. This allowed them to monitor accidents and incidents that had occurred at the home and identify areas that might require improvement.

There was a medication trolley for each floor, and these were stored in the medication cupboard for that floor. The medication cupboard doors were kept locked at all times. The temperature of the medication fridge and medication rooms was monitored regularly and recorded. Packaging was dated when staff started to use the medication so that staff could check that the medication had not been used for a longer period than recommended. We noted that products for external and internal use were not stored separately, as recommended, and the deputy manager told us that they would ensure this happened in future.

Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The packs were colour coded to indicate the time of day the medicines needed to be administered. We checked a sample of medication administration record [MAR] charts and saw that they had been colour coded to match the blister packs; this reduced the risk of errors occurring. MAR charts were accompanied by a sheet that included a photograph of the person concerned to aid recognition for new staff, and details of any allergies. We saw that codes were being used appropriately to record when people had refused their medication, and that an explanation about why the person had refused had been recorded on the rear of the MAR chart for monitoring purposes. There were no gaps in recording.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs [CDs] and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage of CDs and noted they were stored securely. We checked a sample of medicines held against CD records and saw that the stock of medicines held matched the records in the CD book. Two staff had signed the CD book to record when medication had been administered, and we saw that weekly audits had been carried out and recorded to check that the balance of medication and records were accurate. The deputy manager told us that one person had been prescribed more CDs than other people and because of this, their records were audited more frequently.

We saw that MAR charts were being audited on a regular basis. The home's pharmacist had also carried out an audit of medication systems at the home in December 2015 and no concerns had been identified.

There was an audit trail to evidence that medication that had been prescribed by the GP was the same as

the medication delivered by the pharmacy. There were satisfactory arrangements in place for the disposal of unwanted or unused medication.

Records showed that senior staff who had responsibility for the administration of medication had completed training, and this was confirmed by the staff who we spoke with. The manager told us that they [the manager] needed to update their medication training and that this was being arranged. As soon as they had completed this training they would be commencing competency checks with staff who were responsible for administering medication.

We saw the registered provider's crisis [business contingency] plan. The plan advised staff on the action to take in the event of a fire and included the telephone numbers for staff and other people who might need to be contacted in an emergency. The plan also included details of alternative accommodation should people need to be evacuated from the premises. We discussed with the manager how it would be useful for the plan to include advice for staff on the action to take in the event of other emergencies, such as a power failure or flood. On the day of the inspection we noted that, although people had a fire risk assessment in place for their bedroom, they did not have a personal emergency evacuation plan [PEEP] in place. These documents advise the emergency services about the assistance each person would need if they needed to be evacuated from the building. On 4 February 2016 the manager informed us that a PEEP document had been obtained and work had commenced on completing one for each person who lived at the home; these would be stored with The Willows crisis plan.

At the inspection in June 2015 we were concerned that there had been no audit to monitor the control of infection. In October 2015 the manager produced a document that recorded the action they had taken in response to the previous CQC inspection. This included that the rusty boiler in the laundry room had been painted, that the treatment room had been 'cleared out' and that an infection control audit was being carried out each month. We saw that shelving had been provided in the treatment room to make the floor easier to keep clean. We saw that the audit completed on 7 January 2016 recorded that a shower chair needed to be replaced; the manager told us that this was due to be delivered on 28 January 2016. This showed that action had been taken to rectify any concerns identified in these audits. Mattress audits were also being carried out. The audit form included the questions, "Is the mattress seal compromised? Is the mattress malodorous? Is the cover torn or damaged?" This showed us that thorough checks were being undertaken to ensure mattresses were clean and hygienic.

We saw the checklist used by the manager when they carried out 'spot' inspections of bedrooms. We noted that these were carried out on a regular basis and included checks on tidiness and malodour as well as cleanliness of the wash basin, commode / toilet, waste bin, bed and bedding, floor and curtains. The checks recorded that rooms 'passed' or 'failed' following these inspections, and remedial action was taken if the room 'failed' the audit.

People who lived at the home told us they felt the home was clean. One person said, "Very clean." Three relatives told us the home was clean and hygienic. One relative said, "I don't smell any odours and it is clean" and another told us, "I have never smelt anything." However, another relative told us they thought the home was in need of refurbishment and that there was sometimes an unpleasant odour. Two visiting care professionals told us they had never noticed any unpleasant odours at the home but another care professional told us that there had been occasions when they had noticed unpleasant odours. On the day of the inspection we saw that bedrooms were clean and we did not note any unpleasant odours. However, we found that some communal areas required more attention to improve the standard of cleanliness.

We saw that liquid soap and paper towels were being used in communal bathrooms and toilets, although

soap and towels were being used in people's en-suite facilities. We did not see any use of 'communal' toiletries. We saw that there were supplies of disposable aprons and gloves around the home ready for staff to use. We did not see anything of concern in respect of the use of personal protective equipment (PPE) but a visiting care professional told us that they had seen unsafe use of disposable gloves, for example, staff assisting people with personal care and then touching door handles and furniture before taking off the gloves. We fed this back to the manager following the day of the inspection.

We saw that two bathrooms had bath sides that had become loose; these could have caused injury to people using the bath and meant that the bath sides were difficult to keep clean. The manager contacted us after the inspection to tell us that these had been repaired on 29 January 2016.

We saw that most chairs in the home were washable, and a member of staff told us that fabric headboards were being 'phased out' and replaced with wooden ones. This meant that they could be washed regularly to reduce the risk of cross infection.

The home had achieved a rating of 4 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

At the comprehensive inspection on 10 June 2015 we found that there was a breach of Regulation 15 [1][c]. This was because there was insufficient space in the first floor dementia unit to accommodate people comfortably and the treatment room did not provide suitable facilities for people to meet with health care professionals.

At this inspection we saw that some reclining chairs had been purchased for lounge areas on both floors and that the dining room on the first floor had been provided with a small settee and easy chair. However, there were still two dining tables in this room and that made it difficult for people to sit comfortably at the dining table. The manager contacted us after the inspection to tell us that one dining table and three dining chairs had been removed on 27 January 2016. This meant that the room was suitable to be used as a dining room for a small number of people, and as a small seating area when needed.

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 MCA 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. We saw that care plans recorded whether or not people had the capacity to make decisions, the decisions people were able to make and the types of areas that might require a best interest decision.

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 checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order, with the date for renewal clearly recorded. We saw that documentation had been completed appropriately by the manager and that the authorisations that had been agreed by the local authority were in date. We noted that the manager and staff displayed a good understanding of their role and responsibility regarding MCA and DoLS and that they had undertaken appropriate training.

Three relatives who we spoke with told us they acted as Power of Attorney (POA) for their family member. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. We did not check what scope of authority these relatives had or whether this information was recorded in the person's care plan.

People told us that they were consulted about their care and that staff asked for consent before they started to assist people. We saw that people had behaviour management plans in place to guide staff on how to manage situations if people became agitated or showed signs of distress. For example, one person's care plan included advice for staff on how to reassure them when they became anxious to help them to calm down. Staff told us that restraint was never used at the home.

Staff told us that they supported people to make decisions and choices in their day to day lives. One

member of staff said, "We just ask them and see what they would like to do – some like to eat in their own rooms – they choose when to get up and go to bed." Other comments included, "We chat to them, ask them their wishes, where they want to eat their meals" and "We ask them, give them choices." Staff told us they made themselves approachable. One staff member said, "On a day to day basis we ask – communicate."

People were asked to consent to the content of their care plan, to the administration of medication by staff and to photographic evidence being used, and had signed a document to evidence this when they were able to do so. On some occasions we noted that consent forms recorded that the person was not able to sign due to their lack of capacity.

We saw the induction training records for two new members of staff. These showed that the topics of safeguarding adults from abuse, whistle blowing, infection control, moving and handling and the use of mobility equipment, health and safety, the control of substances hazardous to health [COSHH], key working and first aid were covered. One person had commenced work in September 2015 and we saw that they had achieved the Care Certificate by November 2015. The Care Certificate is an identified set of standards that health and social care workers are expected
to adhere to in their daily working life. Staff also told us new care workers shadowed an experienced member of staff as part of their induction training; the number of shifts varied from person to person depending on their previous experience and level of confidence.

Although there was no evidence that new staff had not completed training such as moving and handling and safeguarding adults from abuse before they worked unsupervised on the staff rota, we discussed with the manager that there needed to be clearer records to evidence this.

People told us that staff seemed to have the skills to do the job. Three of the relatives we spoke with told us they thought staff were well trained. One relative said, "Majority are well trained – some are new staff but I have no concerns." Visiting care professionals told us that staff had the skills they required. One person told us, "The long standing staff are very good."

The training matrix recorded that staff had completed training on infection control, safeguarding adults from abuse, fire safety, health and safety, moving and handling, first aid, COSHH, food hygiene or nutrition, MCA and DoLS, equality and diversity and dementia awareness. A small number of staff had also attended training on end of life care, challenging behaviour, stroke awareness, diabetes and pressure ulcer awareness. The discussion we had with staff on the day of the inspection confirmed this.

Ten members of staff had completed a NVQ award at either Level 2 or 3, and a further three members of staff were working towards this award at Level 2. The manager had achieved NVQ Level 5 and the deputy manager had commenced this training award. This showed that the registered provider had made sure that training opportunities were made available to staff so that they had the skills they needed to carry out their roles effectively.

We saw records that showed staff had an annual appraisal and regular supervision meetings. These are meetings when staff have the opportunity to have a one to one discussion with their manager about their performance and any concerns they might have. Staff confirmed they had attended a supervision meeting with the manager and told us they felt "Well supported".

We saw the 'handover' sheets that were used to record any information that needed to be shared with staff. One sheet was produced each day and night to record any incidents or concerns that the next group of staff on duty needed to be aware of. Information was recorded about every person who lived at the home. The

manager told us that, if someone did not work a full shift, the person in charge of the shift gave them brief handover information when they arrived on shift. A staff member told us that staff came in ten minutes early for their shift so they could attend these handover meetings. This ensured that all staff were aware of each person's current care needs.

People's dietary needs were assessed and this information was recorded in their care plan. Records evidenced that the speech and language therapy (SALT) team and dieticians had been involved in a person's care when nutrition had been identified as an area of concern. One person who we spoke with told us they had diabetes and required a special diet. They said, "The food is lovely. I asked for boiled eggs for breakfast and I got them, and I love the salads." We asked staff how they knew about people's special dietary needs. They told us, "It is in the kitchen – cooks know and it is in their care plans – any fortified / special diets come up from the kitchen" and "It is pre-assessed and put in their care plan – and it is written in the diary in the kitchen." Staff also told us special diets were recorded on food and fluid charts. The cook told us they found out about people's dietary needs as soon as they were admitted to the home, and that this information was recorded in the kitchen diary. They said that people were asked each morning what they would like for lunch; there were two choices available. The cook 'plated up' a meal for each person and their name was placed on the plastic cover and served by care staff.

Other people told us they did not have any special dietary needs, and they all said they were happy with the meals provided. Comments included, "Very, very good – I enjoy it", "It is very good – ten out of ten" and "It is alright for me – I like the sausages." We saw that the kitchen diary recorded that this person enjoyed sausages. Another person told us, "I have sandwiches every tea time – my son brings my favourite bread in and the staff use it. I don't like fish and chips so they do me fish in parsley sauce – I would like more variety though." A relative told us, "The food is wonderful – everyone is so kind and helpful."

We observed the lunchtime experience. In the main lounge people did not require any adapted cutlery or crockery, or assistance from staff. In the first floor dining room we saw that people received appropriate assistance when they required it. There was a picture menu available but we saw that it was not open at the correct day in both the ground and first floor dining rooms. Clothes protectors were not offered but some people had napkins 'tucked into' their clothing. Everyone had beef stew and dumplings and we saw the food looked hot and appetising. People were asked if they had finished their meal before their plates were cleared.

We saw that drinks were not placed around the home so that people were able to help themselves. The manager told us that this used to be the case, but one of the people who lived at the home had started to place objects in the drinks so they were not hygienic. Staff were asked to offer people regular drinks instead.

People were weighed as part of nutritional screening. We were concerned that one person's weight records looked to be incorrect, as they had gained a stone in weight in December 2015 and lost a stone in weight in January 2016. The manager told us that this was an error in recording but it seemed that no-one had checked this out and there were no records to evidence this.

The manager had produced a document that recorded the action they had taken in response to the previous CQC inspection. This included that bedroom doors in the dementia unit had been painted different colours to help people to recognise their own bedroom. We saw that additional signage had been provided, such as signs for toilets, bathrooms and the dining room. In addition to this, most people who lived in the dementia unit had pictures on their bedroom door. These included their name but also a picture of something that had specific relevance to them, such as a flower. These pictures had also been provided for some ground floor bedrooms but were continually being removed by one of the people who lived at the

home; an alternative system may need to be used to help people to locate their rooms. Staff told us that they thought the signage in the home helped people find their way around, and relatives did not express any concerns about people finding their way around the home.

People told us they were able to see their GP or other health care professionals when they needed to. One person told us, "I saw him [the GP] yesterday and I have seen a chiropodist" and another person said, "He [the GP] was here yesterday and gave me antibiotics." Three relatives told us that they were kept informed about important events, such as GP visits and hospital appointments. One relative said, "Yes, they rang yesterday to say GP had been and antibiotics given" and another relative told us, "We have had two reviews with social workers and the manager – very happy with it." However, another relative told us they had not been informed of a recent GP visit to their family member." Staff told us they would inform the deputy manager or manager if they felt someone needed to see their GP and they would telephone immediately. A visiting care professional told us that staff had called out the GP when needed for a person they were visiting.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that patient passports included up to date information.

Good

Is the service caring?

Our findings

We saw positive interactions between people who lived at the home, staff and visitors on the day of the inspection. People who lived at the home told us they felt staff cared about them. One person said, "Yes, there are some really good lasses – they are lovely" and another person told us, "You only have to ask them and they will see to you." A member of staff told us they felt staff genuinely cared about people who lived at the home and added that they "Took pride in their job." The relatives who we spoke with also said that staff cared about people who lived at the home, although one relative said, "Yes, staff care but I don't think [Name] has had her hair brushed today."

We asked people if they were kept informed about events at the home and issues that concerned them. Three of the four people we spoke with told us that staff did not have time to talk to them. The fourth person said, "If they have the time they talk to me – it is a very nice place." On the day of the inspection we saw that staff had time to spend with people and that they chatted to them at regular intervals, although we saw one care worker walk through the lounge without acknowledging the people who were present. Most relatives told us they were happy with the level of communication between staff at the home and themselves. One relative told us that their family member had been poorly and was taken into hospital; staff at the home had kept them informed and the care they had received helped their family member to make a good recovery. They said, "I was very pleased with their response and very impressed with the staff."

People told us that staff respected their privacy and dignity. They told us that staff knocked on their bedroom door before entering and we observed that this was the case. Relatives told us that their family member's privacy and dignity was respected by staff at all times. Staff explained to us how they respected a person's privacy and dignity. One member of staff said, "We keep them covered when washing and dressing – keep doors shut" and another told us, "Use towels to cover them over – knock on doors – ask if they want a male or female carer." Both male and female care workers were employed at the home so this request could be met. A visiting care professional told us that one person had specifically requested to be supported by female staff and that this had been acknowledged and followed by staff. Visiting care professionals told us that staff understood the importance of confidentiality although one visiting care professional told us that staff had developed 'bad habits' and could be more discreeet. On the day of the inspection we observed that staff were discreet when asking people if they required assistance to use the toilet or to change their clothes.

We saw that a small settee and chair had been placed in the dining room on the first floor. The manager told us that this had been well used; people were able to see their visitors in private and social care professionals also used the room to hold care plan reviews.

All staff had undertaken training on the topic of equality and diversity. We saw that people's diversity was taken into consideration, and that people's religious and other beliefs were recorded in their care plans to ensure that their wishes for care were met. A visiting care professional told us about one person who was receiving very individualised care from staff at the home. This was based on allowing the person to live their chosen lifestyle.

One relative said that they had mentioned that their family member felt the cold and needed to wear socks. They said, "[Name] has no socks on today." We discussed this with the manager who told us that staff made every effort to encourage people to wear socks but on some days people refused.

A member of staff told us that most bedrooms were locked during the day and that four people who were able to access their rooms independently had their own door key; we observed this to be the case on the day of the inspection.

Relatives told us that staff supported their family member to be as independent as possible. People's care plan recorded the tasks they were able to complete and the tasks they needed assistance with. A member of staff said, "We try to get them to do as much as they can for themselves – try to keep them moving" and another member of staff told us they encouraged independence, "By prompting, encourage them but we get the GP out if their mobility is affected." We noted that staff encouraged people to walk and take part in activities to promote their independence.

Some people's care plans included information that had been obtained about specific illnesses. For example, one person's care plan included information from the National Institute for Health and Care Excellence (NICE) on the dementia pathway. This information helped staff to understand the person's condition and provide appropriate care, support and information to people.

We noted that some people had Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] notices in place and those that we saw had been completed correctly. In addition to this, people had 'end of life' care plans in place when this was something they wished to discuss and plan for.

Good

Is the service responsive?

Our findings

We checked the care plans for two people who lived at the home. We saw that a pre-admission assessment had been completed prior to the person moving into the home. Care staff told us that care plans were developed from this initial assessment as well as information gathered from the person themselves, their family and friends, and from professionals involved in their care. Areas covered in care plans included privacy and dignity, personal hygiene, communication, tissue viability, breathing, behaviour, social interaction, sleeping / resting, mobility, eating and drinking, social needs and end of life care. Some people had more individualised care plans in place for topics such as dysphagia.

Care plans recorded people's daily routines such as the time they liked to get up and go to bed, the support they needed with meals and what they would define as a 'good' or 'bad' day. They also included specific information about how the person wished to be supported, such as, "[Name] likes to brush her own dentures each morning. Her family will bring in her preferred choice of toiletries." Staff told us they got to know about people's individual care needs by reading their care plans, talking to relatives and by spending time chatting with people. Our observations on the day of the inspection indicated that care workers knew people's individual personalities and care needs.

People told us they were not aware of their care plans, but relatives told us that they were aware. One relative told us, "It has been reviewed and anything raised was immediately addressed" and another said, "Social Services come in yearly for reviews to see if everything is OK." However, another relative told us they felt their family member's care plan needed to be reviewed as it was out of date. The care plans we saw had been reviewed and updated in-house each month, although some updates had not been dated so it was not possible to tell when the changes had occurred. More formal reviews were completed periodically by the local authority to check that the person's needs continued to be met by the home. This meant that care plans were up to date and a true reflection of the person's current care needs.

The care plans we saw evidenced that person-centred care was provided and this was supported by three of the four people who we spoke with; a fourth person was not sure about this. A visiting care professional gave us an example of one person who was receiving very individualised care from staff at the home that was based on allowing the person to live their chosen lifestyle.

People told us that their family and friends were made welcome at the home, and family visits were recorded in people's care plans. One member of staff said, "People only have to ask and we will contact them – by phone and visits" and "We encourage visitors and phone calls." We saw several visitors in the home on the day of the inspection; they were offered refreshments and a comfortable chair.

People told us that there were activities for them to take part in. Comments included, "There is a singer here this afternoon" and "I like the quizzes and on a Wednesday I go to the Darby and Joan Club and they come to pick me up." This showed that people were also involved in the local community. Another person told us that they preferred to say and watch the TV in their bedroom and that this choice was respected by staff. Staff told us there were "All sorts of activities – music man comes in, motivation [exercise and mental

activities] and we put films on, quizzes and manicures." They said that staffing levels were sufficient to enable them to spend time with people doing activities. A singer visited the home on the afternoon of this inspection and it was clear they visited the home regularly as they knew people's names. People from the dementia unit were invited to join in the activity and some of them chose to come downstairs to take part.

The manager told us that 'rummage' boxes had been introduced although we did not see these being used on the day of the inspection. These are boxes that are full of interesting items such as bits of fabric, spools of thread, lace, colourful balls and costume jewellery that provide people with something to do and something to 'tidy'. Rummage boxes are often used to alleviate anxiety.

The manager told us that a section where staff could record activities and visits from relatives and friends was being added to the daily record sheet; this meant that staff would be able to record the care and support people had received on one form. This reduced the amount of recording for staff and meant that information would be more easily accessible. Food and fluid charts and 'pain' charts were kept in the daily record sheet book; this meant that all information about people's care was available in one folder.

All of the people we spoke with told us who they would speak to if they needed to express a concern or make a complaint. Three people said they had never needed to make a complaint. One person told us about a complaint they had made and how it had been resolved to their satisfaction. Three of the four people who we spoke with said they knew who the manager was and that they would be happy to speak to her. One person said, "I know who she is and I can talk to her anytime."

Relatives told us they would be happy to speak to the manager or deputy manager if they had any concerns. Three relatives told us about concerns they had raised with the manager; these included concerns about the heating, a broken light bulb and laundry. They all said the issues they raised had been resolved quickly, and the response from the manager had made them feel encouraged to raise issues again. Another relative told us they would speak with the deputy manager but they had not had a reason to complain. One relative commented, "My only complaint is the 'tired' décor."

Staff told us, if someone raised a complaint with them, they would try to deal with it themselves, although if it was a serious complaint they would report it to the manager. They told us that they were certain people's concerns and complaints were listened to.

The manager told us that complaints were recorded on the complaints form and stored in the 'significant events' folder. We saw records in respect of four complaints that had been received. Some of the investigations had been concluded and others had not. One complaint was from a family about uneven paving stones at the homes entrance and work had been carried out to rectify this. The repair of a leaking roof was 'pending'. We noted that some complaints were recorded in the quality assurance folder and some were recorded in the 'significant events' folder; we discussed with the manager how this could make the monitoring of complaints less effective.

People could not remember being consulted about their care or how the home was operated by attending a 'resident' meeting or completing a satisfaction survey. However, we saw that people who lived at the home had been asked if they liked the new picture menus and whether they found them helpful. Records listed people's comments, and the overall outcome was that people liked the menus and said they helped them to choose a meal. There had been a previous survey [although the information was not dated] when people had been consulted about the home's menu. In this survey 100% of participants said they were happy with and enjoyed the meals. They said they liked stew and dumplings, cottage pie, jacket potatoes, sweet and sour and pasta dishes, and some of their dislikes included milk puddings, stuffing and garlic bread. We saw

that stew and dumplings was on the menu on the day of this inspection and that most people chose this option. This showed that people's views were listened to.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a manager in post on the day of this inspection and they had submitted an application to be registered with the Care Quality Commission.

We asked for a variety of records and documents during our inspection and found that these were easily accessible and stored securely.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager had introduced a 'significant events' folder and we saw that this included details of any safeguarding incidents, accidents or deaths, complaints and events that affected the running of the home. One of these events was that the fire alarm was not working; CQC did not receive a notification about this event as required. In addition to this, we saw that two safeguarding incidents had occurred. These had been reported to the local authority appropriately but no notifications had been submitted to CQC. Although CQC had been notified of deaths in the home we had not been notified of these three incidents. This meant that we had not been able to check that these events had been managed appropriately.

This was a breach of Regulation 18(2) Care Quality Commission (Registration) Regulations 2009 which states the registered person must notify the Commission of significant events relating to the health, safety and welfare of service users.

At the inspection in June 2015 we were concerned that the outcome of satisfaction surveys had not been collated and analysed. At this inspection we saw the collated feedback from a professionals survey although because the information was not dated it was not clear when the survey was carried out. We saw that the outcome was positive; 100% of care professionals thought that staff were friendly, kind and professional and said that staff always followed care instructions. Three of the relatives we spoke with said they could not recall completing a satisfaction survey, but one relative said they had completed one about a year ago. The manager told us that relative surveys had recently been distributed and relatives had been asked to bring completed surveys to the relatives meeting, or to send them to the home by the end of the month. All of the relatives we spoke with were aware of this 'resident / relative' meeting that was due to be held the next day. Two people told us that they or another relative would be attending the meeting. The manager assured us that these surveys would be analysed, the information would be collated and feedback would be given to relatives, people who lived at the home and staff.

There had been a previous meeting for people who lived at the home and relatives on 25 September 2015. We saw that twelve people had attended the meeting and that some people had expressed dissatisfaction as the general manager was due to attend but had to withdraw at the last minute. People commented that they felt "Let down, as they never saw anyone from the head office." People also expressed concern about low staffing levels. Since the meeting more staff had been recruited and at this inspection we saw that the home was now fully staffed.

Staff told us that things had improved following feedback received or as a result of the outcome of audits and surveys. One member of staff said, "Menu boards were mentioned and have been implemented, and staffing levels have improved." Two members of staff told us the home met the 'Mum's test." One member of staff said, "I would recommend it – it is a friendly home. I would definitely put a relative in here" and another told us, "I would put my relative in here – it is homely, and it is not regimented."

Staff told us there had been two staff meetings since the new manager started to work at the home in the Summer of 2015. We saw the minutes of a staff meeting that was held in October 2015; these showed the topics discussed included clinical waste, activities, infection control and the staff rota. A specific incident was also discussed; there was an incident when staff argued in front of service users and it was made clear to staff that this was unacceptable. Staff were also advised that they needed to 'sign up' to enable them to complete the Care Certificate. We saw that actions required were dated when they had been completed. For example, staff had 'signed up' to undertake the Care Certificate on 3 November 2015 and 24 November 2015. We noted that there had been a previous staff meeting on 22 September 2015. This showed that there were opportunities for staff to share their views and make suggestions about the service provided at the home.

Staff told us they thought the manager was making improvements. One staff member said, "I think she is doing okay – staffing and general atmosphere have improved" and "She is getting there – she is doing alright."

There were no written values displayed in the home but the aims and objectives were recorded in the home's statement of purpose. The manager described the culture of the home as "A good team", "Good communication" and "Friendly." One member of staff told us the culture of the home was "Open, with good team work between day and night staff" and another said, "We are now more open and we talk more about things that have gone wrong or could go wrong and how we could put things right."

We asked the manager if there were any incentives for staff. They told us that the registered provider invited every employee to a night out at Christmas.

At the inspection in June 2015 we were concerned about the lack of auditing to monitor that the quality of the service provided was being maintained. At this inspection we saw that a variety of audits had been carried out, including audits on care plans, nutrition [including weight records], mattresses, medication, staff supervision, first aid kits and infection control. The aim of the quality monitoring system was to identify any patterns or areas requiring improvement, and we were concerned that they had not identified some of the shortfalls that we identified during this inspection, such as the loose bath sides and a damaged bed. Most of the concerns we identified were rectified following the day of the site visit but we were concerned that these had been highlighted by us and not found during audits undertaken at the home.

We recommend that the service assesses, monitors and mitigates the risks relating to health, safety and welfare of service users.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission of significant events relating to the health, safety and welfare of service users. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because the premises and equipment used by the service provider were not safe for such use. Regulation 12 (2)(d)(e)