PWC Care Limited

Thorn Hall Residential Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 15 October 2015 and was unannounced. We previously visited the service in September 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide accommodation and care for 19 older people, some of whom may be living with dementia. There are two communal lounges, a dining room and several bedrooms on the ground floor, with the remaining bedrooms on the first floor. None of the bedrooms have en-suite facilities. The first floor is accessed by a stair lift.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care

Summary of findings

Quality Commission (CQC). 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 a breach of regulation; this related to the risks associated with the safety of the premises. You can see what action we told the provider to take at the back of the full version of the report.

The home had not been maintained in a safe condition; on the day of the inspection we found that the gas safety certificate and the electrical installation certificate had expired. The roof in one area of the home was leaking and there were two large red buckets in the middle of the floor that created a trip hazard. The environmental risk assessment had identified areas of risk and we recommended that the registered provider reviewed the risk assessment to ensure people's safety was protected.

However, people told us that they felt safe living at the home. We found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

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. The training records evidenced that most staff had completed training that was considered to be essential by the service and that some staff had achieved a National Vocational Qualification (NVQ). Medicines were administered safely by staff who had received appropriate training.

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 had been employed. We saw that there were sufficient numbers of staff employed to meet people's individual needs.

People told us that staff were caring, pleasant and helpful, although we received comments to indicate that some staff were considered to be more caring than others.

People commented that they would like to have more activities to keep them occupied, and we made a recommendation to the registered provider in respect of providing more social stimulation.

People told us they were happy with the meals provided at the home and we saw a picture menu board had been obtained to assist people with cognitive difficulties to choose their meals.

There were systems in place to seek feedback from people who received a service, although quality assurance systems would have been more effective if feedback had been analysed to identify any improvements that needed to be made. Complaints received by the service had been investigated appropriately.

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. We saw that, on occasions, incidents that had occurred had been used as a learning opportunity for staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is not safe.

Requires improvement

The premises had not been maintained in a safe condition.

Staff had received training on safeguarding adults from abuse and moving and handling, and the arrangements in place for the management of medicines were robust.

We saw that sufficient numbers of staff were employed to meet the needs of people who lived at the home.

Accidents or incidents were monitored to identify any improvements in practice that might be needed.

Is the service effective?
The service is effective.

Good

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles, although additional training on dementia awareness would have been beneficial.

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

People told us they had access to health care professionals when required.

Is the service caring?
The service is caring.

Good

People who lived at the home and their relatives told us that staff were caring and we observed positive relationships between people who lived at the home 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, with support from staff.

We saw that people's privacy and dignity was respected by staff and this was confirmed by most of the people who we spoke with.

Is the service responsive?
The service is responsive to people's needs.

Requires improvement

Apart from visitors to the home and watching the television, there was a lack of activities to keep people occupied.

Summary of findings

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

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager if they had any concerns.

Is the service well-led?

Good

The service is well-led.

There was a registered manager at the home who promoted a positive and open atmosphere.

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

Quality audits were being carried out to monitor that staff were providing safe care. Although maintenance of the home had been identified has an issue, timely action had not been taken to make the premises safe.

Thorn Hall Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 October 2015 and was unannounced. The inspection team consisted of an adult social care (ASC) inspector and an expert-by-experience. An expert-by experience is a person who has personal experience of using or caring for someone who uses this

type of care service. 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 home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with three people who lived at the home, two relatives, three members of staff, a social care professional and the registered manager. We observed the serving of lunch and looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment records for one member of staff, training records and other records relating to the management of the home.

Following the day of the inspection we received some positive feedback from a relative of someone who lived at the home. This has been included in this report.

Requires improvement

Is the service safe?

Our findings

We spoke with three people who lived at Thorn Hall and they all told us they felt safe living at the home. One person said, "Yes, very safe, brilliant carers" and another one told us, "Yes, always somebody about." We asked staff how they kept people safe and their comments included, "We check doors are secure, check they are using the correct equipment, make sure no hazards around and keep call buttons near them" and "We use the correct equipment – we check visitors and make them sign in." This view was reiterated by relatives. One relative said, "Yes, there is always staff on duty" and another told us, "They have done everything they can for them to keep them safe – they couldn't have done more."

On the day of the inspection we found that the premises were not being maintained in a safe condition. The lounge carpet had stretched and become uneven; this created a trip hazard. There was a leak in the conservatory roof and two large red buckets had been placed under the leaks to catch the water. This was in a thoroughfare used by people who lived at the home, visitors and staff and posed a trip hazard. On the day of the inspection a dining table was placed under the leaks and the buckets were placed on the table. This reduced the risk of someone tripping over the buckets and we noted that there was still enough room for people to move through this area with ease. There had been a leak in two ground floor toilets and this had damaged the walls. The toilet close to the dining room had a rusty radiator. There was a frayed area in a corridor carpet that created a trip hazard and a water leak had damaged a ceiling in a first floor living room. Some double glazed windows had 'blown' so people could not see through them. This may be the reason why one person told us they thought the downstairs of the home was 'dark'. We saw that there were window opening restrictors in place; we checked a sample on the day of the inspection and saw they were working satisfactorily. However, there were no records of in-house checks to monitor the effectiveness of window opening restrictors.

Some of the areas we identified as requiring maintenance had been recorded in the improvement schedule for 2015. Although two bedrooms had been redecorated and a new carpet had been fitted in the dining room, work to rectify the poor maintenance we identified had not been carried out.

We checked service certificates for maintenance undertaken by contractors. The stairlift and hoists had been serviced in October 2015 and the fire alarm system and emergency lighting had been tested in August 2015. We found that the gas safety certificate had expired on 25 February 2014. Although an engineer visited the home to carry out this test on the day of the inspection, this meant that there had been no valid gas safety certificate in place for over a year. In addition to this, the electrical installation certificate expired on 17 May 2014 and had not been renewed. We discussed this with the registered manager on the day of the inspection and at the time of writing this report we had not received an updated certificate. However, the registered provider has confirmed that an electrician visited the premises on 2 November 2015 to undertake this work.

We saw an action plan in the quality assurance folder that recorded a list of repairs that were needed. The registered person had identified some of the same issues that we identified on the day of the inspection. We saw there was no lock on the door of the cupboard used to store cleaning chemicals and poor storage of Steredent. This meant there was a risk that people could enter areas of the home where chemicals were stored and ingest them, causing them physical harm. These issues were raised with the registered manager on the day of the inspection. They told us that there were plans in place to fit a bolt to the cleaning cupboard door and following the inspection they confirmed that this work had been carried out.

We noted that one fire extinguisher was free standing and not fixed to the wall. We were concerned that this could cause harm to people who lived at the home. We spoke with the Fire Officer who advised that fire extinguishers should be fixed to the wall and we passed this information on to the registered manager.

This was a breach of Regulation 12 (2)(d) 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 care plans listed the risks associated with each person's care. People had risk assessments in place about pressure area care, the risk of falls / falls prevention, safety

in the bedroom, the use of bed rails and moving and handling. Risk assessments highlighted any identified risks to the person, and how staff could minimise these risks to keep people safe.

There were other risk assessments in place in respect of the environment and these had been updated during 2015. One risk assessment was about the safety of the internal staircase. The risk assessment recorded that people only used the stairs when accompanied by a member of staff and that the chair on the stair lift had a lap belt to prevent falls. The risk assessment also recorded that the home had purchased a retractable barrier for the bottom of the stairs to prevent people from walking up the stairs unaccompanied and that this would be fitted as soon as possible. We spoke with the registered provider after the inspection to check if the barrier had been fitted and they told us that the Fire Officer had advised them not to carry out this work.

The registered manager brought their dog into the home each day. There was a risk assessment to record any identified risks and how these could be alleviated. However, we saw that the dog entered the dining room and was moving around the tables whilst people were eating. It also entered a person's bedroom and jumped on a settee used by people who lived at the home. Although no-one who lived at the home expressed any concerns, and people appeared to enjoy the company of the dog, we were concerned that this might be a health and safety risk and that the dog should be restricted to certain areas of the home.

We recommend that the registered provider reviews environmental risk assessments to ensure that any identified risks have been managed and minimised.

There was a suitable policy in place on safeguarding vulnerable adults from abuse. Records evidenced that all staff apart from two had completed training on this topic. The two remaining staff had started the Care Certificate and safeguarding adults from abuse was included in this training; 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. 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 they became aware of to the registered manager or a senior member of staff. Staff also told us that they would not hesitate to use the home's whistle blowing policy if they were concerned about any incidents or care practices at the home.

The registered manager told us in the PIR document that they had robust recruitment policies in place. We looked at the recruitment records for a new member of staff. 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 also to prevent unsuitable people from working with children and vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions of employment. This ensured staff were aware of what was expected of them.

The registered manager told us that there was one member of staff on duty from 7.30 am until 7.30 pm, one member of staff on duty from 7.30 am until 3.30 pm and an additional member of staff on duty from 7.30 am until 12.30 pm. Two staff worked from 3.30 pm until 9.30 pm. On the day of the inspection there were only two care staff on duty in the morning. However, the registered manager was on the premises along with a cook and a domestic assistant. There were two members of staff on duty overnight. Occupancy levels had reduced to eight people and the registered manager considered these staffing levels to be sufficient to meet people's needs. However, the registered manager told us they would be introducing a more straightforward rota with three staff on duty each morning and three staff on duty each afternoon / evening, with two staff on duty overnight.

We checked the staff rotas for a two week period and saw that there had always been a minimum of two care staff on duty, plus a cook over seven days a week and the registered manager on five days a week.

We received differing views on how long it took staff to respond to call bells. One person said, "On a good day it's a couple of minutes wait but on bad days it is about 10 – 15 minutes" although another person told us, "They answer my call button in five minutes usually." However, we observed that call bells were responded to promptly on the

Requires improvement

Is the service safe?

day of the inspection and people told us they thought there were sufficient numbers of staff on duty. One person told us, "There are always three (staff) on days and two on nights."

Relatives told us that there were usually enough staff on duty but there had been occasions when staff had 'struggled'. One relative said, "I usually visit on a Saturday and there were only two staff on a couple of weeks ago. A resident needed a lot of assistance and they struggled to get teas out."

People who lived at the home had personal emergency evacuation plans (PEEPs) in place. These documents record the assistance a person would need to leave the premises, including any equipment that would be required and the number of people that would be needed to assist. There was also a contingency plan in place that advised staff how to deal with unexpected emergencies. This included telephone numbers for staff and telephone numbers for contractors so that all of the information needed in the event of an emergency was available in one folder.

We saw that accidents were recorded appropriately in the home's accident book. Incidents were analysed as part of the quality assurance process. The report included details of complaints received, restraints, safeguarding alerts submitted, admissions to Accident and Emergency units, serious injuries and the development of pressure sores. We saw that one person had a record of regular falls, and this had resulted in a referral to the falls team to request further advice and support. This showed that incidents at the home were being monitored to check for any patterns that had emerged or any improvements that needed to be made.

We observed the administration of medication and saw that this was carried out safely. We noted that some MAR charts did not include a photograph of the person concerned; photographs aid new staff with identification and reduce the risk of errors occurring. The registered manager told us that they were aware of this and were in the process of taking new photographs for medication records.

We checked recording on MAR charts and found this to be satisfactory. There were minimal gaps in recording and when medication had been stopped by a health care professional this had been recorded on the person's MAR chart. These entries would be improved if there was a record of who had given this instruction and the date. There were specific instructions for people who had been prescribed Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. We saw that, if people did not require 'as and when required' (PRN) medication, the appropriate codes were recorded on MAR charts.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. 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 blister packs were colour coded to identify the time of day the tablets needed to be administered.

Blister packs were stored in the medication trolley, which was locked and stored in the registered manager's office when not in use. The medication fridge was stored in a separate cupboard and we saw that the temperature of the room and the fridge were recorded to ensure medication was stored at the correct temperature.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. Controlled drugs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We saw that the medication system had been audited in February and May 2015. These recorded some areas that required improvement and records indicated that appropriate action had been taken.

There was an effective stock control system in place, although we noted that there was no date recorded on the packaging of medication that was not stored in blister packs. Recording the date of opening would ensure the medication was not used for longer than the recommended period of time. The arrangements in place for medication to be disposed of were satisfactory.

We saw that all staff that had responsibility for the administration of medication had completed appropriate training, and we saw evidence of competency checks that had been carried out to ensure that staff had the skills to carry out this role.

Requires improvement

Is the service safe?

We did not check infection control on the day of the inspection but we noted that the carpet in the corridor / lounge close to the office was dirty and required either replacing or a deep clean.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The registered manager was aware of the principles of MCA and DoLS, how they impacted on people who used the service and how they were used to keep people safe. One person's care plan included information about a DoLS application that had been submitted to the local authority for their consideration and the registered manager was waiting for a decision.

The registered manager told us that two people had been diagnosed with dementia and that another person had the signs and symptoms of having dementia but did not have a formal diagnosis. The MCA legislation is designed to ensure that, when a person does not have capacity to make important decisions, any decisions made on their behalf are made in their best interests. We saw that a person's capacity had been assessed and their ability to make decisions considered in each area of their care plan. There was evidence that best interest meetings had been held to assist people with decision making. People told us that staff always consulted with them and asked for consent before they helped them with care.

Care staff had not completed formal training on MCA / DoLS. However, we saw that clear information was displayed in the home about MCA / DoLS, confidentiality and the whistle blowing policy, and we noted that this information was based on good practice guidance. We saw that all staff had signed to evidence they had read this information.

There were clear signs on toilet and bathroom doors but no signage to assist people to identify their bedroom, apart from names and numbers. However, people told us they had no problem finding their way around the premises or when mobilising, and on the day of the inspection we observed this to be the case.

We saw that information about dementia was available in the registered manager's office. The home was following the National Institute for Health and Care Excellence (NICE) guidance "Supporting people to live well with dementia." Although staff had undertaken training on dementia awareness, a health care professional told us they felt staff required more specialised training on this topic.

Some people choose to have their meals in their bedroom. We saw that staff took them their cutlery and a napkin as early as 10.35 am even though lunch was not served until 12.15 pm. This indicated to people that it was almost lunchtime and could be confusing for people with cognitive difficulties. We discussed this with the registered manager and she acknowledged that this could be confusing; she told us she would ensure that people were not given their cutlery until lunch was due to be served.

Staff told us that there was a policy of 'no restraint' at the home and that they had never needed to use restraint to manage a person's behaviour.

We asked people if they thought staff had the skills they needed to carry out their roles effectively. Everyone said that the staff had the right skills but one person said, "Most do although there is one who is a bit fast." They added that this member of staff was occasionally a "Bit rough with them." However, another person told us, "Yes, they are brilliant – can't thank them enough" and another said, "I think they are pretty good – some are in a hurry but they are never nasty." Both of the relatives who we spoke with told us that staff seemed to have the skills they needed to carry out their duties.

The staff who we spoke with told us they shadowed experienced care workers as part of their induction training and the staff records we saw confirmed this. The records we saw for a new member of staff included information about their induction training, the shadowing of experienced care workers and that they had commenced the Care Certificate.

The overall training record showed that staff had undertaken training on moving and handling, first aid, fire safety, dementia awareness, medication and safeguarding adults from abuse (Levels 1 and 2). Some staff had also attended training sessions on end of life care and infection control. Four staff had started the Care Certificate. Staff told us about training they had completed during the previous year; this included training on fire safety, use of the hoist, dementia awareness, health and safety and the Care Certificate. This meant that staff had received training that gave them the skills to carry out their roles effectively.

Good

Is the service effective?

Staff told us they felt well supported by the registered manager and that they attended supervision meetings. We saw the records of supervision meetings and noted that they included discussions about the person's training needs and achievements.

We received positive feedback about the meals provided at the home. People told us that staff knew their likes and dislikes and that there was ample choice. Comments included, "Good, no complaints, good choice. I have porridge and toast for breakfast and choices at lunch and tea time and a hot drink at 7.30 pm", "Very good food and very good staff" and "Very good in the past few months. We get a choice at lunchtime – I like fish and we get scampi, which I like."

We observed the lunchtime experience. We saw there was a menu on display in the dining room that listed two choices of main meal. We saw that meals were 'plated up' by the cook and served by care staff. Care staff did not ask people for their choice of main meal but we were told that they had been asked earlier in the day; people were offered a choice of dessert. People were offered a drink of tea after their meal. We saw that special cutlery was used but no special crockery was required.

An evaluation of meal provision had been carried out from May – August 2015. This recorded, "We are creating a photo menu board to help service users with dementia or sensory loss. Service users commented positively on fresh food and portion sizes." On the day of the inspection the registered manager told us that this menu board was now ready to use.

We saw that care plans recorded people's specific dietary needs and the cook showed us a chart on the kitchen wall that recorded this information. We noted that not all special diets that we had observed in people's care plans were recorded on this list. However, our discussions with the cook indicated that the cook and staff were aware of each person's special dietary requirements. One member of staff told us, "Fortified diets are provided and would be written in daily notes" and another said, "It is in the care plans – all the information is in there. Fortisips are recorded in their chart – usually in their room." The chart the staff member referred to was a food and fluid chart; these are used to monitor a person's food and fluid intake when this had been identified as an area of concern.

We saw that people had been referred to dietetic services if concerns had been identified about their nutritional intake. We saw that one letter advised the home to follow the Nutrition Mission process; this is an initiative that has been introduced by the NHS to encourage people not to have supplements but to have fortified diets to increase their calorie intake.

The home had achieved a rating of 5 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.

The registered manager told us in the PIR document that the home was part of the "Care Home Scheme"; this meant that a named GP visited the service every four – six weeks to review people's health care needs. People told us they had good access to health care professionals. One person said, "They ask for a GP if I need one. I used to see the district nurse for ulcers on my legs but these are better now. I see a chiropodist regularly." Staff told us they would tell their line manager if they were concerned about a person's health and that they would call the GP; one member of staff added that they would also record this information. There was a record of any contact people had with health care professionals, including the reason for the visit and the outcome of the visit.

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 one person had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form in place and this had not been recorded in their patient passport; the registered manager agreed that this should be included and told us they would update the patient passport.

Good

Is the service caring?

Our findings

We asked people who lived at the home if they felt staff really cared about them. They all told us they did. One person said, "If there is ever anything wrong they sort it" and another told us, "Yes, they pop in and check on me." This view was supported by the relatives and staff who we spoke with. A member of staff told us, "Yes, staff genuinely care." A health care professional told us that some staff seemed to care more than others. However, they added, "There is a nicer workforce now than in the past though."

A social care professional who we spoke with told us "Staff have a lovely demeanour. The people who live here always look well cared for and well presented." We noted that people who lived at the home were well presented, appropriately dressed and wearing suitable footwear. People's individual lifestyle choices and family relationships were understood and respected by staff. A relative told us, "I have only praise for staff at the home. They are exceptionally professional and patient with (my relative) and nothing is too much trouble."

On the day of the inspection we observed positive interactions between people who lived at the home, visitors and staff that demonstrated staff were caring and compassionate. Staff told us that they read people's care plans and that these included information in a document called a 'personal fact file' that helped them to get to know the person, such as their family relationships, their hobbies and interests and their individual likes and dislikes. These provided information for staff about the person that would help them build up relationships and enable them to support people to live their chosen lifestyle.

Staff told us that, when someone was first admitted to the home, they would speak to the person themselves, their family and friends and any health and social care professionals so they could get to know their individual needs.

Visitors told us that they were kept informed about the well-being of their relative. One person said, "Yes, they tell me if there is anything I need to know, like if a doctor has visited."

The registered manager told us in the PIR document that staff from the home were involved in a "Celebrating Dignity in the East Riding" event that was organised by the local authority that commissioned a service from the home. All of the people we spoke with told us that staff respected their privacy and dignity. They described how staff knocked on doors before they entered and how they protected their modesty when assisting them with personal care. Staff told us that it was important to respect a person's right to confidentiality and that they always knocked on doors before entering and made sure they closed the door and left the room when people were assisted to use the toilet to protect their privacy and dignity.

However, one visitor told us that their relative had used the call bell during the night to ask for assistance to use the toilet. They had been told that they could go to toilet in their incontinence pad, which had upset them. This had happened on more than one occasion. We discussed this with the registered manager who told us this was definitely not the policy of the service and that they would take action to make sure this did not happen again.

The registered manager also recorded in the PIR document that they promoted "Holistic care planning that also supports independence." Relatives also told us that people were encouraged to be as independent as possible. One relative told us, "They do try. When he can do things they let him – they let him shave himself this morning." On the day of the inspection we observed that people were encouraged to carry out tasks for themselves when they were able to do so.

One person had been assigned an Independent Mental Capacity Advocate (IMCA); the Mental Capacity Act 2005 states that anyone over the age of 16 who lacks capacity and has no family or friends able to speak for them and who is the subject of a decision regarding serious medical treatment or a long-term move to accommodation arranged by the local Authority or NHS must have an IMCA. There was information available in the home to inform people about other advocacy services; this meant people were able to contact advocacy services independently without having to ask for support to do so.

Staff told us that communication at the home was good and that they had 'handover' meetings each time a new group of staff started their shift. They discussed medication, diet, personal care and general well-being for each person who lived at the home. They said that, if they had been absent from work for a few days, they would read the home's diary and handover notes to ensure they had up to date information about everyone who lived at the home.

Good

Is the service caring?

People told us that staff shared information with them but commented that staff were in a hurry. One person said, “They never have the time to sit and talk to me, they talk to me as they are getting me ready.” However, staff told us that they did spend time with people. One person told us that they spent 20 minutes every day with people who they were key worker for, and that they also spent time with them at other times during the day. On the day of the inspection we saw that some staff spent more time talking with people than others, although the registered manager spoke with all relatives who visited the home and chatted to people who lived at the home throughout the day.

Requires improvement

Is the service responsive?

Our findings

All of the people we spoke with told us that activities no longer took place. One person said, "There used to be, but no more" and another told us, "There are no activities – I would like to have some." A third person told us, "In my care plan they have put that I don't join in any activities but they don't have any. I would love to play cards or something." The relatives who we spoke with were not aware of any activities that took place in the home. The records we saw in care plans included information about visits out with family members and watching the TV, but no other activities.

Staff told us that there were enough staff to support people to take part in activities. They told us that the mobile library visited the home once a month and that people could play dominoes and listen to music. They also said they sometimes took people to the shops in their wheelchair. However, we did not see any activities taking part on the day of the inspection and there were no records to evidence that activities were taking place on a regular basis. We discussed this with the registered manager. They explained that the activities coordinator had left. There were plans in place for staffing levels to be increased from the week following the inspection. The registered manager said that this meant there would be three staff on duty in the afternoons and staff would have more time to take people out into the local community and to facilitate more activities.

We noted that there was no enclosed garden area to enable people to walk outside safely and without support. We discussed this with registered manager and they told us they would consider whether there was an area of the garden that could be enclosed and made safe.

Although we acknowledged that people needed to have a calm atmosphere to concentrate on eating their meal and to enjoy their meal, we observed that there was little conversation between staff and people who lived at the home at lunchtime; staff served the meal and then left the dining room. We felt that this was a missed opportunity for staff to socialise with people.

We recommend that the registered provider considers ways of engaging people in stimulating activities.

One relative told us that they had been impressed by a device the home had obtained to enable their relative to read books by scanning them with a 'mouse'. This device displayed the writing in large print on a computer screen; this has enabled them to read any book they wished.

We saw that people had visitors on the day of the inspection and everyone who we spoke with told us that their visitors were made welcome. Visitors told us they were able to visit at any time although they had been asked to avoid mealtimes. Some services have 'protected mealtimes'; this is when visitors are asked not to visit over mealtimes so that people can take their time to eat their meals and have a positive mealtime experience. We observed that visitors were offered a drink when they arrived at the home and had good relationships with staff.

All of the people we spoke with told us that they felt that care at the home was centred around them. One person told us that they had helped develop their care plan, and the care plans we reviewed had been signed by the person concerned if they had the capacity to do so. However, one person told us that their care plan included some information that they had not agreed to. We discussed this with the registered manager who explained to us about the meetings that had been held with this person to discuss their individual needs so that their care plan could be amended and agreed. It was clear that efforts were being made to meet this person's specific needs.

Care records included assessments in respect of pressure area care, moving and handling and nutrition and there were supporting risk assessments in place. Care plans covered areas such as general health, personal care, night care, mobility, eating and drinking, pressure area care and social care. They recorded the person's care needs, strengths, any risks involved in their care and any identified goals. Care plans were reviewed and updated monthly, with a more formal review each year (or more frequently if required). We saw that care plans were a good reflection of a person's care and support needs and they had been updated appropriately. In addition to this, staff were required to read each person's care plan every month to ensure they were aware of any updates, and had to sign to evidence they had done this. Updates included information such as antibiotics being prescribed and any concerns about weight gain or loss. Staff told us that this enabled them to provide person-centred care.

Requires improvement

Is the service responsive?

We asked people if they felt they had choice and control over how they were supported. People told us that they did make choices, such as what time to get up and go to bed, what to wear, what meals to have and where to take their meals. One person told us, "I get up and go to bed when I want and always go to the dining room for my lunch" and another said, "I try to keep to a routine." Staff told us they supported people to make choices. One care worker told us that they asked people about their choices and another said, "We go around at mealtimes and ask them their choice, and they can get up and go to bed when they choose." A relative told us, "Our family visit on a regular basis and we have observed staff spending a lot of time with (our relative). They are always very polite and ensure that their needs and also their choices are respected."

People told us that they would speak to the registered manager if they had any concerns or complaints, but they had not needed to. One person said, "I would see the manager but I have never had to" and another told us, "I just go to the office and talk to her (the manager) – she is lovely." Relatives supported this view. One relative told us, "I would see the manager, but I have never had to" and another said, "I would see one of the staff."

Staff told us they would tell the registered manager if someone had raised a concern with them. They also said they felt people's concerns and complaints were listened to.

We checked the complaints log and saw that some information of concern shared with the registered manager by CQC had been recorded and there was a copy of the detailed response. This showed that the complaint had been dealt with effectively using the home's complaints procedure. Staff told us that this information had been shared with them and there had been some learning from the incident.

Good

Is the service well-led?

Our findings

The service had a manager who was registered with the Care Quality Commission. They had been the registered manager since 2011 and this provided a level of consistency for the service. The manager had achieved a management qualification.

A health care professional told us, "(The manager) is a lovely person and recently seems to have taken more control. The home has been better led during the last few months." We also spoke with a social care professional who told us that staff at the home were keen to learn and enthusiastic about learning. They told us, "(The manager) leads by example – she is very approachable and is also keen to learn." These learning opportunities were used to drive improvement within the home.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. However, we did see one inappropriate comment written in a person's daily notes in their care plan. We discussed this with the registered manager on the day of the inspection and they assured us that this matter would be dealt with.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

Both of the relatives we spoke with told us there they had not attended relative meetings or received a satisfaction survey. However, both said that they felt there was a positive culture at the home and they felt they could approach staff or the registered manager at any time and get a positive response.

We asked staff about the culture of the home. One member of staff said, "It is a really pleasant and nice atmosphere – everybody gets on with everybody" and another staff member told us, "I think it is friendly here – they keep us informed." They added that the home was well managed. A third member of staff described the culture of the home as, "Respect, open, privacy, people lead their own lives, family atmosphere."

A survey had been distributed to people who lived at the home in March 2015 and five had been returned. We checked these surveys and saw that all of the responses were positive. Surveys had also been distributed to health care professionals (only one had been returned); the responses were positive and one comment made was, "Have seen a positive change in the way staff respond to us and patients, and the manager seems really 'on the ball' and works with us."

We saw a lot of thank you cards that had been sent to staff from relatives of people who were living at or had lived at the home. Two relative surveys had been completed in January 2015 and three had been completed between June to September 2015. We saw that all of the comments were positive. The outcome of surveys would have been more helpful if a report had been produced recording the overall outcome and shared with people who lived at the home, relatives, health care professionals and staff.

Although staff did not receive satisfaction surveys, they told us that they attended staff meetings and that they were held approximately every three months. We saw the minutes of the staff meeting that took place on 13 October 2015. The topics discussed included that a CQC inspection was due, staff training, the Christmas rota, the well-being of people who lived at the home, creams, bathing, rota changes, tea-times, moving and handling, smoking and staff attitude. Staff told us that they could express their views in staff meetings and that they were listened to.

The registered manager carried out a variety of audits on a regular basis. This included audits for care plans, infection control, hand hygiene, medication, safeguarding events, complaints and accidents / incidents. We saw that the audits included any areas that required improvement or action to be taken. For example, the care plan audit for January 2015 recorded that not all patient passports were up to date and that staff needed to read the updates in care plans. There was an additional note to record that this had been completed by staff when re-checked on 27 February 2015. The hand hygiene audit in February 2015 recorded that staff needed to be reminded about the 'bare below the elbow' rule. We saw that there was a poster displayed in toilets to remind staff about this. One audit had been carried out to assess the risk of people choking.

Good

Is the service well-led?

The registered manager told us in the PIR document that suggestions were treated seriously and learning from complaints was used to improve the service. The registered manager and staff were able to describe situations when there had been learning from accidents and incidents.

The quality assurance folder included an action plan dated 1 October 2015; this recorded a number of repairs that needed to be carried out plus evaluations in respect of hospital and GP appointments, staff training, activities and 'resident' meals. The evaluation of meal provision recorded, "We are creating a photo menu board to help service users with dementia or sensory loss. Service users commented positively on fresh food and portion sizes." We noted that the creation of a photo menu board had been actioned.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not being provided in a safe way for service users. The premises used by the service provider were not safe to use for their intended purpose or used in a safe way. Regulation 12 (2)(d).