Lillibetcare Ltd

Lillibet Lodge

Inspection report

6 Rothsay Road
Bedford
Bedfordshire
MK40 3PW

Tel: 01234340712

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 November 2015. It was unannounced.

Lillibet Lodge is registered to provide a service for up to 25 people, who may have a range of needs, including old age, physical disabilities, mental health, dementia and sensory impairments. Nursing care is not provided. During this inspection, 24 people were living in the home.

A registered manager was in post. 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.

There were sufficient numbers of suitable staff. However, improvements were required to ensure the way staff were deployed ensured peoples' safety and met their individual needs.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, improvements were required to ensure staff checked people had received their creams as prescribed, before recording these as given.

People had enough to eat and drink. Assistance was provided to those who needed help with eating and drinking, in a discreet and helpful manner. However, improvements were needed to enhance people's dining experience, and to ensure all staff are familiar with people's dietary preferences.

We saw that people were given opportunities to be actively involved in making decisions about their care and support. However, improvements were required to ensure records relating to people's care are up to date and contain sufficient detail, to demonstrate the care and support being provided.

Systems were in place to monitor the quality of the service provided. However, improvements were required to ensure these are more effective, in order to drive continuous improvement within the service.

Staff had been trained to recognise signs of potential abuse and keep people safe. People felt safe living at the service.

Processes were in place to manage identifiable risks within the service, and ensure people did not have their freedom unnecessarily restricted.

The provider carried out proper recruitment checks on new staff to make sure they were suitable to work at the service.

Staff had received training to carry out their roles and meet people's assessed needs.

We found that the service worked to the Mental Capacity Act 2005 key principles, which meant that people's consent was sought in line with legislation and guidance.

People's healthcare needs were met. The service had developed positive working relationships with external healthcare professionals to ensure effective arrangements were in place to meet people's healthcare needs.

Staff were motivated and provided care and support in a caring and meaningful way. They treated people with kindness and compassion and respected their privacy and dignity at all times.

People's social needs were provided for and they were given opportunities to participate in meaningful activities.

A complaints procedure had been developed to let people know how to raise concerns about the service if they needed to.

There were effective management and leadership arrangements in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

There were sufficient numbers of suitable staff. However, improvements were required to ensure the way staff were deployed ensured peoples' safety and met their individual needs at all times.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, improvements were required to ensure staff checked people had received their creams as prescribed, before recording these as given.

Staff understood how to protect people from avoidable harm and abuse.

Risks were managed so that peoples' freedom, choice and control was not restricted more than necessary.

The provider carried out proper checks on new staff to make sure they were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to have sufficient to eat and drink. However, improvements were needed to enhance people's dining experience, and to ensure all staff are familiar with people's dietary preferences.

Staff had the right support to carry out their roles and responsibilities.

The home acted in line with legislation and guidance in terms of seeking people's consent and assessing their capacity to make decisions about their care and support.

People were also supported to maintain good health and have access to relevant healthcare services.

Is the service caring?

Good

The service was caring

Staff were motivated and treated people with kindness and compassion.

Staff listened to people and supported people them to make their own decisions as far as possible.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive

People received personalised care that was responsive to their needs. However, improvements were required to ensure records relating to people's care are up to date and contain sufficient detail; to demonstrate the care and support being provided.

Systems were in place to enable people to raise concerns or make a complaint, if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to support the service to deliver good quality care. However, improvements were required to ensure these are more effective in order to drive continuous improvement within the service.

We found that the service promoted a positive culture that was person centred, inclusive and empowering.

There was a registered manager in post who provided effective leadership for the service.

Lillibet Lodge

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 25 November 2015. It was carried out by one 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.

Before the inspection, we checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law. In addition, we asked for feedback from the local authority, who have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences.

We spoke with five people living in the home and observed the care being provided to the majority of people at some point during the day, including lunch time and when medication was being administered. We also spoke with the registered manager, the provider, deputy manager, three care members of staff - including one senior, the cook, the administrator, the housekeeper and four relatives / visitors.

We then looked at care records for three people, as well as other records relating to the running of the service - such as staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Requires Improvement

Is the service safe?

Our findings

People told us there were sufficient numbers of staff to keep them or their relative safe. One person told us: "There is usually enough staff; I don't usually have to wait long for help." Another person said: "Staffing seems okay, they're not intrusive but I know they are around." A visitor added: "There always seem to be enough staff, they don't appear rushed, I don't often hear call bells." Staff we spoke with were content with staffing levels in the home, although several staff and relatives spoke about staff being loaned out to the sister home for the service on occasions. They felt this could be detrimental to the people living at this service. The registered manager confirmed there were staff vacancies across the two services but recruitment was underway. Staff talked to us about the arrangements for covering the vacancies. One member of staff told us: "We are a team here and we never mind getting called to cover a shift." The registered manager confirmed that this approach had meant they had not had to call on agency staff to cover.

During the inspection we observed that there were enough staff on duty to meet people's day to day needs. However, there were occasions when we observed that people were being placed at potential risk, because staff were busy carrying out tasks and were less visible at key points of the day. For example, we saw one person who displayed behaviours that challenged, encroaching on other peoples personal space. On several occasions they went up to a person who was sitting in an armchair, and shook them by the shoulders as they slept. Staff were quick to respond when it was pointed out to them. The registered manager also told us she was already working to increase the number of care staff on each shift; to reflect the number of people living in the home and their assessed needs. Staff rotas we looked at showed that staffing levels had increased recently from four to five care staff on each day time shift. The provider also said they would review how staff were deployed; to provide better supervision in all areas of the home at key times.

Systems were in place to ensure people's medicines were managed so that they received them safely. People we spoke with told us they felt their medication was managed well. One person said: "The staff do all tablets fine. If I want painkillers I just ask." Another person told us: "Staff are good, they never forget my meds." Staff we spoke with demonstrated a good understanding about medication processes such as administration, management and storage. One member of staff told us: "Only a senior can do the meds [medication] but if someone wants painkillers I tell the senior." A senior member of staff confirmed: "As a senior I do the medicines. I also order them and speak to the pharmacy."

We saw that the home used an electronic system utilising bar code technology to manage people's medication. Staff explained that each person / medication had their own unique barcode which helped them to ensure people were given the right medication at the right time. We saw the system used a traffic light approach which made it clear to see who had received their medication and who had not. Stock levels updated each time medication was given; enabling staff to know when new medication was required.

We observed people receiving their medication and noted that the person administering explained the purpose of each medication and gained people's consent before administering. We also noted that PRN (as

required) medication was considered, but was not given unless it was actually required. This demonstrated that the service did not control people's behaviours by excessive or inappropriate use of medication. Where PRN medication was for pain relief, people were asked whether they needed it or not first. Our only concern was that prescribed creams, which were kept in people's rooms and applied by care staff, were being signed off on the system as given by the person administering. When asked, they explained that they trusted the care staff to apply creams prescribed for people. However, without actually observing this or checking each time with the care staff, they could not be confident that this had happened. We spoke with the registered manager and provider who acknowledged our concern and told us they would introduce an additional sign off sheet in people's rooms; to enable care staff to record at the time of applying any prescribed creams.

Everyone we spoke with confirmed that they felt safe living at the service; many people had lived there for several years. One person told us: "I feel very safe here." Another person added: "If I was worried about anything I would report it to the manager." Family members also told us they felt their relatives were safe.

Staff told us they had been trained to recognise signs of potential abuse and were clear about their responsibilities in regard to keeping people safe. One member of staff told us: "They are definitely safe in here, we have good training and I know how to spot both physical and psychological signs of abuse." Another member of staff said: "I know what to look for and I would speak up." We saw that information was on display which contained clear information about safeguarding, and who to contact in the event of suspected abuse. Records confirmed staff had received training in safeguarding, and that the service followed locally agreed safeguarding protocols. Records also showed that safeguarding was discussed with staff during their individual supervision meetings.

People talked to us about how identifiable risks to individuals were managed. One person living in the home told us: "I do have freedom here, but staff remind me to take care and ask for help if I need it." A relative added: "Dad has fallen in the past; he now has a room that he is happier with and can walk around. He has a fall mat so that helps at night." We saw that individual risk assessments were in place to manage risks to individuals in a way that did not restrict their freedom, choice and control more than necessary. These included areas such as moving and handling, pressure care and falls. Risk assessments we read provided clear information about managing the risks identified and had been reviewed regularly; to ensure the care being provided was still appropriate for that person. We observed staff on a number of occasions supporting people as they moved about the home. They demonstrated safe techniques and supported people in a reassuring manner.

One person required complete support to maintain their skin integrity. Staff were able to outline the plan of care for that person, including the reasons for turning them regularly. They were aware of the risk to the person of developing pressure ulcers and took pride in explaining that no one living in the home had a pressure ulcer on the day of the inspection. The registered manager told us that observation sheets had been introduced following recommendations from a safeguarding incident at the sister home for the service. This demonstrated that actions were taken when incidents happened, in order to learn lessons and inform practice. We saw that people at risk of developing pressure ulcers had specific care plans in place to minimise the risks, which included information about how often they should be turned and about their food / fluid intake. We observed that staff followed these plans of care correctly and recorded the care they provided on the observation sheets.

The registered manager spoke to us about the arrangements for making sure the premises was managed in a way that ensured people's safety. She told us that in the event of an emergency and needing to evacuate the home, arrangements had been made with two other local homes, to ensure the wellbeing and safety of people using the service. Relatives reported that the fire alarms were tested weekly, and the maintenance

man was often round checking windows and general safety issues. Records showed that systems were in place to ensure the building and equipment was safe and fit for purpose, and that regular checks were carried out. Clear information was also available regarding fire safety and the arrangements to follow in the event of a fire.

The home's administrator and registered manager described the processes in place to ensure that safe recruitment practices were being followed; to ensure new staff were suitable to work with people living in the home. We were told that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. We looked at a sample of staff records and found that all legally required checks had been carried out. On the day of the inspection some of these checks were confirmed for newly appointed staff.

Requires Improvement

Is the service effective?

Our findings

People told us they had enough to eat and drink and that they enjoyed the food provided at the home. One person said: "[The] food is always good, I'm a diabetic and they are very careful." Another person said: "I choose beforehand, the food is great and at the right temperature." A relative echoed these comments by adding: "He really enjoys the food, they know his likes." Another relative said: "I have seen the food quite often, it's very good."

On the day of the inspection, the lead cook for the home was on leave so another member of staff prepared the meals. We saw evidence that people's nutritional needs had been assessed, with any specific requirements such as soft options or assistance with eating outlined. The registered manager showed us an example of a nutrition plan that had been developed for someone who had recently moved into the home. The information was personalised, in terms of their food and drink preferences.

We spent time observing how staff supported people during lunch. We noted that tables were laid; providing a visual clue for people living with dementia to support them in recognising that it was time to eat. Assistance was provided to people as required, in a discreet manner and people were encouraged to eat and drink. We observed one person who did not like the first option of meal offered to them. The person required a soft meal which was provided, but we saw that all the components of the meal had been blended together. This meant the person did not have their meal presented in an appetising way that encouraged enjoyment. Nor did it provide them with the opportunity to choose the parts of the meal they preferred. A staff member patiently offered the person other options, which we noted corresponded with their dietary preferences as outlined in their nutrition plan. This approach worked, and the person was observed eating and drinking food and drink of their choosing. Another staff member was observed supporting someone else to eat. We heard them explaining to the person about the food that was being offered to them before putting it to their mouth. People confirmed afterwards that they had enjoyed their meals, and we observed that most people ate well.

However, we noted that some people's dining experience was affected by the order of service. For example, people eating at the same table were not served together; resulting in one person having to watch other people at their table eating in front of them. We noted that this caused them to get frustrated at times. Another person, who was also not served until later, was observed being disruptive to others by going around and touching them whist they tried to eat. One person became cross and walked out. The registered manager and provider acknowledged our observations and said they would review the order of service and staff deployment at meal times; to enhance the experience for people and maximise the opportunity to enjoy their meals in a relaxed way.

Records showed that people's weight was being monitored, to support staff in identifying any potential healthcare concerns. We saw that where people were at risk from not eating and drinking enough, that staff checked and recorded what they ate and drank. Food and drink was provided at regular intervals throughout the inspection, although one person raised concerns about the fact that their relative did not have a drinking glass in their room, so they did not have a drink within easy reach. This was remedied as

soon as it was brought to the attention of staff.

We looked at the food intake record for one person who was vegetarian, and read that they had been given fish cake to eat. We spoke to the registered manager and checked the person's care plan and established that they did not eat fish. The registered manager carried out further investigations after the inspection. She told us that the person had in fact been given a vegetarian burger, but staff had not known what it was, so had guessed that it was a fish cake. On the day of the inspection we spoke with a member of staff who clearly told us that the person did eat fish. This raised concerns about inconsistencies in staff knowledge about the people's dietary preferences. It also raised concerns about the accuracy of the records maintained by staff. The provider acknowledged our concerns and told us after the inspection about the actions they intended to take to address these. This included re-visiting the issue with staff, using reflective practice and improved information about people's dietary preferences. During the inspection the registered manager also took immediate steps to update the person's care plan and the information available to kitchen staff, to draw attention to the fact that the person was a vegetarian.

People confirmed they received effective care from staff with the right skills and knowledge. One person said about the staff: "They're good; they know what they are doing. They often go off for training." Another person told us: "I have a lot of confidence in the staff; the new ones shadow the seniors." Relatives echoed these comments. One relative added: "Staff know what they're doing, they are competent. They have good training."

Staff talked to us about training that was offered. One member of staff told us: "We have a regular training programme; safeguarding and manual handling are key." Another staff member said: "I had dementia training, that's been useful as there is some challenging behaviour here. I learnt distraction and diffusion which I have used." A third member of staff talked specifically about the induction training they had received and said: "Induction is for 10 days, a mix of shadowing and learning on the job as well as the care certificate." The care certificate was introduced in April 2015 to ensure staff working in services such as this are caring, compassionate and provide quality care.

Records showed that a number of staff were in the process of completing their care certificate training. The registered manager showed us observation sheets that had been completed by senior staff to support this process. These provided clear information, and demonstrated each new staff member's knowledge and competency in the different areas being assessed.

We also spoke with a member of staff who did not have a direct caring role in the home. They told us they were supported to attend training on subjects such as safeguarding and dementia awareness, because this provided them with important knowledge and an understanding of the needs of people they came into close contact with on a regular basis. We observed care interactions throughout the day and found staff to be supportive and caring. They demonstrated a good knowledge of each person and a senior member of staff was always visible and available for advice.

A training matrix had been developed which provided information to enable the registered manager to review staff training and see when updates / refresher training was due. This confirmed that staff had received training that was relevant to their roles such as induction, safeguarding, Deprivation of Liberty Safeguards (DoLS), moving and handling and dementia awareness. We noted that some training was in need of updating. The registered manager was able to provide information about courses that had been booked for staff in the following couple of months, in order to address this.

Records showed that staff meetings were being held on a regular basis; to enable the registered manager to

meet with staff as a group, and to discuss good practice and potential areas for staff development. Staff also confirmed they received individual supervision, which provided them with additional support in carrying out their roles and responsibilities.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was working within the principles of the MCA. The registered manager explained that a locked door policy was in place, to keep people safe. She told us that people were assessed to determine their capacity and to see whether they were able to come and go from the home, without restriction. Some people were able to do this. For other people, who had been assessed as lacking capacity and were at risk if they were to leave the home without supervision, DoLS applications had been made. We saw evidence of DoLS applications at various stages, depending on how long people had lived at the service. We saw that relatives, where appropriate, had also been included in decision making and longer term planning. One relative confirmed this by telling us: "He's safe and happy here, I understand things much better. They have explained DoLS to me."

Throughout the inspection we observed staff seeking people's consent. Although some people did not communicate using many words, we observed that they were able to demonstrate their consent clearly through other methods such as actions and physical movement. Staff showed that they understood people's needs well and they encouraged people to make their own choices and decisions, as far as possible. People were seen to respond positively to this approach.

People confirmed they were supported to maintain good health and have access to relevant healthcare services. One person told us: "If I need a doctor the senior calls them in, it all happens quickly." Another person said: "The nurse comes to give my insulin and checks my blood." A third person added: "If I have to go to a hospital clinic, a carer comes with me and we go in a taxi." We observed this happening during the inspection. Rotas showed that a named person was on duty for escort duty.

Staff told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support. One member of staff told us: "[The] GPs are very good, they are interested in dementia and that's a real help." Another staff member highlighted the good relationship with the district nurse team and told us they felt they were very supportive. They told us that if they had any concerns, for example about pressure care, they could consult the district nurses when they called. Additional daily support was also in place from the local complex care team. This is a nurse led service for local care homes which aims to prevent unnecessary hospital admissions and GP call outs. Staff spoke highly of the support they received from this service.

Records showed that visits to and from external health care professionals were recorded. A visitor confirmed that staff always kept them informed about their relative's wellbeing and any changes to their health care needs.

Good

Is the service caring?

Our findings

People confirmed that they or their relative were treated with kindness and compassion. Lots of people spoke positively about the care and support they received. One person told us: "I have a good relationship with the carers, they know me well." Another person told us: "They find out how I'm feeling, I'm very happy here." A third person added: "They are not in my face it's very flexible to my needs."

Relatives also provided positive feedback about the service such as: "They do care for him well; they know he likes a joke and they have a laugh" and "They cared for the whole family throughout, it feels warm and friendly and the staff are lovely." Another visitor commented: "Staff took time to find out how residents were feeling and what they needed."

We observed many positive interactions between staff and the people using the service throughout the inspection. All of the staff demonstrated a good understanding of the needs of the people they were supporting. Their approach was meaningful and personalised. For example, when one person became upset, a staff member stopped and held their hand. The person responded positively and visibly calmed. On another occasion a member of staff was heard greeting a person in their first language, which was not English. This showed that the member of staff had made the effort to acknowledge the person's identify, and to engage with them in a way that was meaningful to them. One member of staff told us: "I give good care and I know others do too. I would have any family member here without hesitation." Another staff member added: "I come here to care and that's what I do." The registered manager showed us a quiz that she had developed, which she told us she would introduce as an on-going agenda item from the next staff meeting. The quiz had been designed to help the registered manager to assess how well the staff knew the people they were caring for and supporting, by asking questions about their needs and their past history.

A call bell system was in place so people could call for assistance when they needed to. The registered manager showed us that she was able to audit the system in order to check staff response times. Records we looked at showed that call bells had been answered promptly, within two minutes. One person living in the home told us: "The call bells don't ring for long, they seem to answer them quickly," Another person said: "Sometimes I have to wait if I use the call bell at night but not very long."

People confirmed they felt involved in making decisions about their care, support and day to day routines. One person told us: "I do feel involved in what happens, it works well, I have my say." Another person said: "I can go to bed when I want, no set time, just when I'm tired." A relative added: "I have been to a review of the care plans, they are very personal. I do understand them and we discussed DNAR (do not attempt resuscitation)." Staff told us that tasks were allocated to them by the senior each shift. One staff member said: "The senior decides who is having a bath or shower each day but you can discuss that." This showed that there was scope for staff to support people to exercise choice, independence and control.

People told us that they were treated with dignity and respect. One person told us: "They usually knock on the door before entering even if it's ajar." Another person said: "They know I like my own space and they don't hassle me to join in." Relatives echoed these comments by adding: "I have watched the staff with

others, they are very respectful" and "The door is shut when he is being attended to."

Throughout the inspection we observed that staff promoted people's privacy and dignity. They were seen to use discretion in the way they organised and provided care and support at all times. For example, we observed staff asking people if they wanted to wear an apron to protect their clothes at lunch time. We also saw a member of staff place a blanket over someone who had chosen to come into the communal area in clothing that exposed their legs. The person accepted the blanket and this showed that the person's dignity was considered and respected.

All the relatives we spoke with told us they were able to visit without restriction. It was clear from our observations that relatives felt included and at ease with the staff. We read some recent written feedback from a relative thanking the staff for the care they had provided to someone at the end of their life. They had written: 'you are a wonderful bunch of people, doing a marvellous job. I am so glad we found you'. Another relative had written to convey their appreciation and had included: 'Lillibet for love' in their message.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were able to contribute to the assessment and planning of their care. They also confirmed they had choice and control over their day to day lives, and felt their need for freedom was respected. One person told us: "I go out on my own, to the shop and for a walk. Staff respect my need for freedom." Another person said: "I go back to my room early evening, staff know I prefer this and they come and chat to me there." Relatives felt that care was centred on the need of their family member and told us they had often witnessed staff discussing this with people living in the home. Records showed that relatives were encouraged to provide information about people's life history, routines and individual preferences, before they moved in. When people moved in at short notice, we saw that the home obtained information from the person's social worker, where this arrangement was in place. We looked at the assessment information for one new person and found this was consistent with the care described by staff as being provided to them in the home.

Care plans were being reviewed regularly, to ensure the care and support being provided to people was still appropriate for them. Records we saw had just been signed and dated however, with no further updates provided. One person's care plan set out that they had a sensor mat next to their bed, to alert staff if they got up at night. We checked the person's room and the mat was not there. The registered manager explained that the person had moved to a ground floor bedroom close to where staff were based; minimising the risk so they no longer required a sensor mat. This had not been updated in their care plan, or highlighted when it had been reviewed however. Similarly, a care plan to manage someone with behaviour that challenged did not provide adequate information for staff to be able to deflect or manage their behaviour, and ensure the safety of other people in the home in a consistent way. A person living in the home told us: "Some residents get angry in here and if the staff don't deal with it we would be in danger." The registered manager talked about staff training in escalation techniques, but these had not been included in the person's plan. Other records showed there had been aggressive incidents between the person and other people living in the home, so the information in the care plan did not adequately address this concern. The registered manager updated the care plan whilst we were on site.

Daily records were being maintained to demonstrate the care and support provided to people. However, records we looked at were brief and contained comments such as: 'no problems or concerns' and 'fluids encouraged'. This meant we could not be clear whether the person had received any fluids or what care had actually been provided. One person had a care plan stating that they should remain as independent as possible in terms of managing their personal care. However, their daily records only made reference to the fact that they had received personal care, not how much they had been involved. There was therefore no way of establishing how well the person was doing or whether there had been a change in their ability to manage their own personal care. The registered manager told us she had also picked up on this as an issue and had raised it with staff. However, she also told us that she would provide staff with clearer information, including an example detailing the level of recording that should take in place, in order to demonstrate the care provided to people. In addition, she showed us an electronic care recording device which she was trialling with a view to using in the home. The system provided prompts to staff, to remind them what to record and when.

People talked to us about their hobbies, social interests and about activities that were provided by the home. One person told us: "There is a good crowd here, I like the activities but they are not always on." Another person said: "There is a girl who does activities but she's not always here." A third person added: "I sometimes go out for coffee with my family or a carer if they have time." Relatives told us that activities took place. One person said: "We had a big family party here on his birthday, the staff were great." Another relative added: "Activities do happen; dogs visit and residents can go to the park with them." We saw the results of the most recent quality monitoring surveys however, completed by people, relatives, staff and other professionals. We noted that activities featured in the feedback provided by many people, including nine staff members who all thought more activities should be offered to people. The corresponding action plan recorded that the registered manager had talked to staff at a meeting about spending more time taking people out for walks and coffee/ice cream - weather permitting, and a named member of staff had been identified to take the lead for activities in the home.

We saw that there was a list of weekly activities on display outside of the office. Many of the people we spoke with were not aware of this however. Staff told us that the activity lead for the home was not working on the day of the inspection and we noted that no activities took place during the morning. The television was on in the main lounge, and a radio was also playing songs popular in the 1980s. People were visibly not engaged with this music. People who were able to mobilise independently were seen going out into the garden whenever they chose and one person was seen reading. We observed periods of time when many people were sat around with little to do, some drifting in and out of sleep. During the afternoon however, a relative provided entertainment. She played the keyboard, dressed up and provided the opportunity for a sing song for people to join in with. Many people were heard joining in with the singing, and really seemed to enjoy the show. The provider took on board our observations and said they would review staff deployment; to maximise opportunities for staff to spend more quality time with people.

People told us they would feel happy making a complaint if they needed to. They told us that staff were approachable, and they would feel comfortable talking to them if they were unhappy about something. They also told us that they felt listened to if commenting on the service; they didn't see it as complaining. One person told us: "I just talk to the staff if I have a problem, things get sorted out quickly." Another person said: "I speak to the senior if there's a problem but it gets resolved quickly." The home's statement of purpose included clear information about the process people should follow if they had any concerns. The registered manager told us she had not received any formal concerns or complaints since our last inspection in April 2014, but added that she had an open door policy and that people could come and talk to her at any time. A relative confirmed this by saying: "I see the manager often. I have made an appointment in the past for a formal review but mostly I just go to the office." Another member of staff added: "We are always open to suggestions and encourage residents and relatives to speak to us." This showed that arrangements were in place for people to raise concerns and for these to be acted on.

Requires Improvement

Is the service well-led?

Our findings

The registered manager talked to us about the quality monitoring systems in place to check the quality of service provided. She showed us that satisfaction surveys were given out to people, relatives, staff and other professionals; to gain their feedback on how well the service was doing, and to see if there were areas that could be improved. An action plan had been developed to address these areas, but we noted it did not contain information about who would be responsible for carrying out the actions and when by. This made it difficult to measure any progress that might have been made.

Other internal audits were taking place such as room safety and cleanliness checks, call bell response times and hot water temperatures. We were also shown a new care plan audit tool that had been introduced recently. We saw an example of a completed care plan audit and were concerned that this had not been carried out effectively. The audit covered 12 different care plans for one person, but the person actually had 20 care plans in place. This meant that eight had not been included in the audit. Within these eight included key areas such as management of aggression and DoLS (Deprivation of Liberty Safeguards). Although required actions had been identified as part of the audit, such as the need to review the person's care plan and risk assessments, once again there was no information about who should undertake this task and by when. This meant that although there were arrangements in place to monitor the quality of service provided to people, audits had not been carried out in a way that would adequately drive continuous improvement. The registered manager told us she had already identified a need for someone to take responsibility for managing quality monitoring within the service and confirmed she had identified someone for the role.

People told us there were opportunities for them to be involved in developing the service such as satisfaction survey feedback and face to face contact with the manager and staff. One relative told us they felt that a family newsletter would also be helpful to inform them of any plans or changes. Staff told us they had arranged meetings for people living in the home in the past but there hadn't been much interest in these meetings. A 'statement of purpose' had been developed, providing useful information to support people in understanding more about what they should expect from the service, including information about staff recruitment checks and training, DoLS (Deprivation of Liberty Safeguards), visiting arrangements, meals, activities and how to raise concerns.

The service demonstrated good management and leadership. We met the registered manager, provider and deputy manager on the day of the inspection. Everyone spoke positively about the management of the home and felt they were approachable. Most people also knew the manager's name and reported seeing her often. A relative told us: "It all seems well organised and staff know what they're doing." Another relative said: "I see the manager around a lot." Another visitor added: "The manager is good; she has the resident's best interests at heart. She tries to do things that will enrich the lives of residents." Staff confirmed this by adding: "I feel supported by the manager. I have progressed and been promoted under her" and "I like it as it's a happy place to work, no one is afraid to speak up if things aren't right." The registered manager confirmed she felt well supported by the provider and that appropriate resources were available to ensure the wellbeing and safety of people living in the home. Throughout the inspection we found the registered manager to be open and transparent. She and the provider responded positively to our findings and

feedback.

Systems were in place to ensure legally notifiable incidents were reported to us, the Care Quality Commission (CQC). Our records showed that the registered manager regularly reported these incidents as required.

Staff we spoke with were clear about their roles and responsibilities across the service. The registered manager showed us some laminated prompts that had been developed for staff to keep with them, providing essential information about their key roles and responsibilities. One staff member told us: "We have staff meetings where we can discuss any issues." Another staff member said: "The team know what to expect, the workload is set out clearly." We observed staff working cohesively together throughout the inspection and noted the way they communicated with one another to be positive and supportive.