# Eldercare (Halifax) Limited

# Oakhaven 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? | Requires improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This was an unannounced inspection carried out on the 27 July and 7 August 2015. At the last inspection in February 2015 we found we found the provider had breached seven regulations associated with the Health and Social Care Act 2008.

At the last inspection we found the provider did not make appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified and skilled and experienced staff to meet people's health and welfare needs and that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We saw that before people received any care or treatment they were not asked for their consent and where people did not have the capacity to consent, the provider did not act in accordance with legal requirements. Applications for the Deprivation of Liberty Safeguards had not been considered for people whose liberty may be deprived.

Standards for hygiene and cleanliness were not effectively maintained and managed in all areas and the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We also found the provider did not take proper steps to ensure that each person was protected against the risks

# Summary of findings

of receiving care or treatment that was inappropriate or unsafe. People did not have their social needs met and were not protected from the risks of inadequate nutrition and dehydration.

We told the provider they needed to take action and we received a report in May 2015 setting out the action they would take to meet the regulations. At this inspection we found improvements had been made with regard to these breaches.

Oakhaven Care Home is a large detached property situated in Oakwood on the outskirts of Leeds. The service offers accommodation for up to 24 older people. It is fairly close to shops and public transport links into the centre of Leeds. The home has two communal lounges and a dining room. There is also parking available and gardens to the rear of the home.

At the time of the inspection there was no registered manager 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 and associated Regulations about how the service is run.

At this inspection we found that overall people were cared for by sufficient numbers of suitably trained staff. We saw that staff now received the training and support required to meet people's needs. People's needs were assessed and care and support was planned and delivered in line with their individual care needs.

The service was clean and hygienic and equipment and the premises were well maintained and service regularly.

People who used the service told us they were happy living at the service. They said they felt safe and staff treated them well. We saw care practices were good. Staff respected people's choices and treated them with dignity and respect.

Appropriate arrangements were in place to manage the medicines of people who used the service. However, protocols for the use of 'as and when' required medicines needed to be put in place to ensure staff had guidance on the circumstances of their administration. People were encouraged to maintain good health and received the support they needed to do this.

People who used the service enjoyed a balanced healthy diet. Mealtime experiences in the home were good and people received the support they needed. The range of activity available in the home had improved to meet the needs of people who used the service. However, some people said they were bored at times and would like to do more.

There were systems in place to make sure people were not deprived of their liberty unlawfully and we found that mental capacity assessments were specific to the decisions being assessed and showed who had been involved in the assessments as is required by the Mental Capacity Act 2005. People were asked for their consent to their care and support.

Robust recruitment procedures were in place and appropriate checks had been undertaken before staff began work. Staff knew how to recognise and respond to abuse appropriately. They could describe the different types of abuse and had received training on safeguarding vulnerable adults.

Staff spoke positively about the manager of the home saying they were approachable. They said they had confidence in the manager. There were effective systems in place to assess and monitor the quality of the service; which included regular audits of the home.

# 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?**

Requires improvement

The service was not consistently safe.

Staffing levels were overall provided as planned by the home and sufficient to meet people's needs. However, some people who used the service and their relatives said the home would benefit from more staff at times.

Medicines were overall, managed safely for people. People we spoke with told us they felt safe. Systems were in place to identify, manage and monitor risk, and for dealing with emergencies. The home environment was clean and safe.

The recruitment process was effective and robust which helped to make sure staff were safe to work with vulnerable people.

**Is the service effective?**

Requires improvement

The service was effective.

The provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

Staff could describe how they supported people to make decisions, enhance their capacity to make decisions and the circumstances when decisions were made in people's best interests in line with the requirements of the Mental Capacity Act (2005).

Staff received training and support that gave them the knowledge and skills to provide good care to people.

People's nutritional needs were met. Records we looked at showed there was a varied and balanced diet offered. People had regular access to healthcare professionals, such as GPs and dieticians. Prompt referrals were made when any additional health needs were identified.

**Is the service caring?**

Good

The service was caring.

Staff understood how to treat people with dignity and respect and were confident people received good quality care.

People were supported by staff who treated them with kindness

People were involved in making decisions about their care and staff took account of their individual needs and preferences.

**Is the service responsive?**

Requires improvement

The service was not always responsive.

# Summary of findings

People were provided with a range of activity within the home. Some people however, said they were bored at times and would like to do more.

There were systems in place to ensure complaints and concerns were fully investigated.

People's needs were assessed before they moved in to the service and care plans developed from this information. However, there was little evidence of how people who used the service or their relatives were involved in this process.

**Is the service well-led?**

The service was not always well- led.

The management team were, approachable and provided guidance and support to the staff team.

Systems for monitoring quality were effective. However, the home's policies and procedures needed to be updated to ensure staff had access to current practice that governed the home.

People who used the service and their relatives were asked to comment on the quality of the service to help drive improvements.

**Requires improvement**

# Oakhaven 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.

This inspection took place on 27 July and 7 August 2015 and was unannounced.

At the time of our inspection there were 15 people living at the service. We spoke with eight people who used the service, two visitors, and nine members of staff which included care staff, the cook, the cleaner, the manager and the area manager. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at eight people's care records and the medication records of 15 people. We also spoke with a visiting health professional.

The inspection was carried out by two adult social care inspectors, a specialist advisor in governance, a specialist advisor in nursing care, and an expert-by-experience who had experience of older people's care services and dementia care. 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 our inspection, we reviewed all the information we held about the home, including previous inspection reports. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires improvement

# Is the service safe?

## Our findings

At the last inspection we rated this domain as inadequate. There were not sufficient numbers of staff to meet people's health and welfare needs, standards for hygiene and cleanliness were not effectively maintained and risk assessments and management plans had not been completed when people were clearly at risk.

At this inspection, people we spoke with told us that they felt safe. One person said "I feel quite safe here. I've never felt in any danger at all." Visitors we spoke with said that they felt confident that their relative was safe and well cared for. One visitor said "Overall I'm very happy. [Name of manager] is improving things. It's looking up." All the people we spoke with said that they liked the staff, and we observed staff speaking with people who used the service in a friendly and respectful manner.

We saw staffing levels had been assessed using a dependency tool to ensure they were safe and there were sufficient staff to meet people's needs. The manager said this assessment was carried out each month or whenever the needs of people who used the service changed. Our observations showed that staff were coming and going in the two lounges that were in use and there were some short periods of time when there were no staff present, but staff were circulating regularly with drinks and chatting with people who used the service. We also saw staff were regularly going to see people who chose to spend time in their rooms.

One visitor and two people who used the service said that they felt there were not enough staff. The visitor said, "They had a few issues at the beginning, but overall I'm happy with how (Dad's) looked after. I've got to know the staff and I feel confident he's safe. They could do with a few more staff at times; well, at least a floater, because they get so busy and pulled in all directions. The last time this issue came up, they came from head office and said they keep to the standards required. Trouble is, it's the minimum standards. The new manager has bucked things up a bit and made some positive changes."

Most of the staff we spoke with said they felt there were overall enough staff to enable them to meet people's needs well and they did not have concerns about staffing levels. Comments included: "It is so much better now, much improved, feel you can spend quality time with people", "It's massively improved and meeting everyone's needs" and "Staffing is much better than it was, feels calm and relaxed, people are well cared for." However, one staff member said that when staffing levels were reduced to two staff after 6pm it could be difficult to always meet people's needs in a timely way.

We looked at the staff rotas and saw that for a number of days prior to our inspection, staffing levels were on some days reduced from three staff to two from 6pm – 8pm. We discussed this with the regional manager. They said they had introduced this in response to reduced occupancy in the home. After our discussions, the area manager decided to increase the staffing level back to make sure there were three staff available until 8pm each day to ensure people who used the service were properly supervised. On the second day of our inspection we saw this had been introduced and maintained. The area manager told us their dependency tool assessment showed they had enough staff at night to meet people's needs. There were currently two staff available 8pm – 8am to cover the night shift. The area manager said they would monitor and keep this under review.

A number of practical steps were now in place to address the daily risks of cross infection. For example, anti-bacterial gel dispensers were located throughout the home. We observed all staff washed their hands appropriately between tasks and had disposable gloves and aprons to support people with their personal care tasks. Staff had undertaken training in infection prevention and control. This meant the staff had the knowledge and information they needed to minimise the risk of the spread of infection which they demonstrated during the day of our inspection as they carried out practical tasks. We spoke with a cleaner about the arrangements for keeping the service clean and hygienic. They told us there was adequate time to keep all areas clean on a day-to-day basis. Our observations indicated the area was clean and free from malodours. We were told there were adequate supplies of cleaning products and protective clothing at all times.

We completed a tour of the premises as part of our inspection. We looked at five people's bedrooms, bath and shower rooms and various communal living spaces. We saw radiators throughout the home were protected. Hot water taps were controlled by thermostatic valves thus protecting people from the risk of scalds. We found all floor coverings were appropriate to the environment in which

# Is the service safe?

they were used. All floor coverings were of good quality and properly fitted thus ensuring no trip hazards existed. We inspected records of the stair-lift, hoists, gas safety, electrical installations, water quality and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out. We saw that Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances.

Staff told us that some people whose bedrooms were on the ground floor were unable to safely access the bathroom or shower room on the ground floor as the space available meant the hoist could not fit in. We spoke with the manager and area manager about this. They told us there was one person who was only able to have a bed bath due to this issue. We were provided with documentary evidence to show that work was to commence on the bathroom in August 2015 to make it bigger and therefore safer for all people in the home to use.

All care plans reviewed had case relevant risk assessments completed and were observed to be updated monthly and the relevant changes added to individual care plans. Staff demonstrated good knowledge about people who used the service, identified to be at high risk of pressure sores. One staff member said, “I know the signs to watch out for when I apply the cream and if I see any redness, I let the manager know straight away.” Another staff member said, “I know how important it is to help her move or stand up for a while.”

We looked at people’s medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete. Medicines were administered to people by trained care staff. We were told people were assessed as to their capability to self-medicate. Whilst no people had been found capable of self-medication the process demonstrated the provider was attempting to maximise people’s independence.

We conducted a sample audit of seven medicines to check their quantity. We found on all occasions the medicines could be accounted for. We found people's medicines were available at the home to administer when they needed them. Our scrutiny of the MAR sheets and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed. Some medicines had been prescribed on an ‘as necessary’ basis (PRN). However, no PRN protocols existed to help care staff consistently decide when and under what conditions the medicine should be administered. We made the manager and regional manager aware of this.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine’s cabinet and controlled medicines register and found all drugs accurately recorded and accounted for. We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. The application of creams was recorded on a separate sheet containing a body map and the areas where the cream had to be applied. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and storage temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We spoke with staff about their understanding of protecting vulnerable adults. Staff had an understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. Staff were aware of the whistle blowing policy and how to report concerns. Staff we spoke with told us they had received training in safeguarding vulnerable adults and had opportunity to discuss their training with the manager and colleagues. Records we looked at confirmed most staff were up to date with this training or a course was booked in for those staff who needed refresher training.

The manager and area manager demonstrated a good understanding of safeguarding issues. They were aware of their responsibilities to safeguard the people who used the service. The area manager showed us the safeguarding log

Requires improvement

# Is the service safe?

which demonstrated there had been five potential safeguarding issues raised from March 2015 - June 2015, which had been reported to the local authority as a safeguarding alert and notified to the Care Quality Commission (CQC), in accordance with the Health and Social Care Act 2008 requirement. The provider had policies and procedures for safeguarding vulnerable adults; however, this had not been reviewed since November 2012. The area manager acknowledged that policies were in need of review and told us that the operations manager and owner were reviewing all policies.

There were effective recruitment and selection processes in place. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. We looked at the recruitment process for two members of staff and saw this was properly managed.

There were systems in place to monitor accidents and incidents and we saw that the service learnt from incidents and made appropriate referrals to protect people from harm such as referrals to the falls team of Gp's. Accidents and incidents were reviewed for patterns and trends and the appropriate remedial action put in place to try and prevent re-occurrence. An independent consultant had carried out a health and safety audit in May 2015 to assist the service in their management of health and safety matters. A recommendation had been that the home set up health and safety meetings to look at issues such as falls and accidents. The area manager said they had yet to do this.

Requires improvement

# Is the service effective?

## Our findings

At the last inspection we rated this domain as inadequate. We saw that due to gaps in staff training people were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard. We also saw before people received any care or treatment they were not asked for their consent and where people did not have the capacity to consent, the provider did not act in accordance with legal requirements and applications for the Deprivation of Liberty Safeguards (DoLS) had not been considered for people whose liberty may be deprived. We also found people were not protected from the risks of inadequate nutrition and dehydration.

The provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

At this inspection we found improvements had been made to make sure staff received the training they needed to carry out their role. We looked at the training records and saw staff had received a range of training which included; safeguarding adults, fire safety, first aid awareness, dementia, falls, moving and handling, food safety, mental capacity act and DoLS and nutrition. Staff spoke positively about the training they had received. Comments included; "I feel really supported to do any training that I want, it's so much better than before" and "I've done all the safeguarding and mandatory training and I know that updates and other training is available." There were systems in place to make sure staff received refresher training. Records showed were any training was due or outstanding it had been booked in to a training plan. We saw new staff completed induction training. We looked at the records for two new staff. Both their induction packs were seen to be fully completed and signed by themselves and a Senior Carer who acted as their mentor. People who used the service said that they felt that the staff knew what they were doing and were competent.

Staff said they felt well supported in their work and received regular supervision. Two staff told us they had recently had a supervision meeting which enabled them to discuss their role and future training needs. One staff member said, "I really want to progress to senior carer and do medication training." We saw supervision documents were completed with written evidence of discussions on training completed, which showed staff's competency was checked. However, we noted that some staff's supervision records did not show evidence of future action points or training that had been discussed. The area manager agreed the records needed to be improved to fully reflect what was discussed at supervision meetings. Two of the staff we spoke with said they had had a recent annual appraisal and they had found this useful. One said, "It's a good opportunity to discuss things and find out how you are doing, I am all for it."

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw people were asked for their consent before any care interventions took place. People were given time to consider options and staff understood the ways in which people indicated their consent. The staff we spoke with told us they would always seek the consent of people before they carried out any personal care interventions. Staff showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions.

Staff spoke about their training in dementia awareness and how they supported people who used the service who were living with dementia. They said they gave people time to communicate their needs and choices and understood that dementia affected people in different ways. One staff member said, "You have to understand the individual and how they communicate what they want." We saw signage in the home had improved to enable people who lived with dementia to find their way around. Signs had been produced showing words and pictures to aid people's understanding. We also saw that they had words translated in to Urdu to assist people who spoke this language.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberties Safeguards (DoLS) which applies to care homes. We spoke with the manager and area manager about the Mental Capacity Act 2005 and (DoLS). We found their collective knowledge of the legal frameworks to be sufficient to safely and legally carry out care. No people were subject to DoLS authorisations. Our observations of the environment and people's care plans suggested the provider utilised a number of methods

# Is the service effective?

which may constitute a deprivation of liberty. Care plans indicated pressure mats were in use to detect people's movements and observation records showed people were receiving hourly checks as to their well-being.

We found two people had been assessed as being without mental capacity to make decisions about their care and had a diagnosis which indicated a significant disorder or disability of the mind. The manager confirmed some people were under constant supervision and they would be prevented from leaving the home should they choose to do so. Our discussions with the manager assured us they would as a matter of urgency review all people at the home who had been assessed as lacking mental capacity and reflect on the need to seek authorisation from supervisory bodies where necessary. On the second day of our inspection we saw progress had been made with this and applications had been forwarded to the supervisory body.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware these documents must accompany people if they were to be admitted to hospital.

We looked at the home's menus and could see that two meal options were offered daily for both lunch and tea-time. The laminated menus were available in the dining room to enable people to make menu choices. We saw that the menu for the full week was varied with nutritional balance of protein, carbohydrates and fresh vegetables. We saw that dessert options always included a fresh fruit option. When we spoke to the cook, they said, Although we offer the two options, if anyone wanted something different, I would happily prepare it for them" and "I prepare soft diets for residents who need it and always try and make it look as appetising as possible."

We observed the lunch time meal in the home. The choice at lunch was between corn beef hash with potatoes, carrots and Yorkshire pudding, or egg and chips. Dessert was chocolate gateau and cream, ice cream or yoghurt. Several people had second helpings of the main course and we heard people comment on the food saying it was nice.

Food was served from a heated trolley. Portions were generous and the food was well presented and looked appetising and hot. People received support and encouragement to eat their meals. Although we saw one person had their protective apron removed and then waited for another staff member to come to assist them with wiping spilled food from their face.

Some people chose to have their meals in their rooms, some chose to sit at the dining area of the lounge, others chose to stay where they were seated in the lounge areas. On the first day of our inspection we saw the meal service was still slow and people were seated waiting for their meal for up to half an hour before it was served. Most people did not seem affected by this and had a drink while they were waiting. However, we noted that two people fell asleep with their heads on the dining room table. We discussed this matter with the manager and area manager and they agreed to look at better staff deployment during meal service. On the second day of our visit we saw the cook was now serving the meals and care staff were assisting and supporting people which led to an improved meal service.

We were told that a culturally appropriate menu had been introduced for a Muslim person who used the service. We spoke with the cook who told us that Halal food was prepared and made available at every meal. We also saw in the care records that it had been noted 'I am a Muslim and I only like to use my left hand to eat with and I often use my fingers. I like to use a clothes protector for meals so please ask if I would like one." This showed the service was respectful of the person's cultural and nutritional needs.

Most people said that they liked the food. One person said, "The food is nice and I have lots of cups of tea." Another person said "It's a bit hit and miss", and one relative made reference to the home not being able to find a permanent chef. The area manager confirmed they were currently recruiting for a chef. However, the person who was covering on a temporary basis told us they were not leaving until a permanent chef was found.

Drinks were being offered regularly throughout the visit to ensure people were properly hydrated. When one person appeared confused as to which type of squash they wanted, the member of staff brought both jugs (blackcurrant or orange) to help them choose.

Records showed that arrangements were in place that made sure people's health needs were met. We saw

Requires improvement

# Is the service effective?

evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. We saw that people who used the service were weighed monthly or weekly as indicated and action taken if any changes. We spoke with one visiting health professional during our inspection. They were positive regarding their involvement with the service.

Good

# Is the service caring?

## Our findings

At the last inspection we rated this domain as requires improvement. We saw that care plans were not up to date on moving and handling needs and there was no evidence of involvement in care planning from people who used the service or their relatives. We also saw that a person where English was not their first language was at risk of isolation. At this inspection we found the provider had taken appropriate action and improvements had been made.

We observed good interactions between staff and people who used the service. Staff spoke kindly and respectfully and appeared to know people well. All the people we spoke with told us that they liked the staff. There was a friendly atmosphere in the home. People who used the service said they were well looked after. One person said, "Very well looked after thank you, nothing is too much trouble for them." All the people we spoke with described staff as 'nice', thoughtful' and 'caring'. Staff were encouraging and supportive in their communication with people. People who used the service enjoyed the relaxed, friendly communication from staff. There were a few visitors during the day of the inspection. Visitors appeared to visit freely and were welcomed warmly.

People looked well presented in clean, well-cared for clothes with evidence that personal care had been attended to and individual needs respected. People were dressed with thought for their individual needs and had their hair nicely styled. We noted at one point that a person who used the service had become dishevelled after eating and drinking. Staff attended to this with thought for the person's dignity. A visiting health professional said they thought people who used the service were cared for well. They said they always found people well-presented whenever they visited the service.

Staff we spoke with said they provided good care and gave examples of how they ensured people's privacy and dignity were respected. Staff said they were trained in privacy, dignity and respect during their induction. They could describe the individual ways they cared for people, which included specific moving and handling needs.

We saw signage around the home was now in English and Urdu, and the home had sourced an Urdu newspaper, for a person who used the service to assist them to keep in touch with news and events relevant to their culture. We saw this person reading their paper, smiling and saying good morning to all who passed their room. The manager also informed us that a local Mosque had been contacted to enable the staff to get guidance on religious requirements for this person and to also obtain some social support for them. Staff showed a good awareness of the person's religious and cultural needs and the need to provide privacy during prayers.

We saw when care interventions such as assisting people to get to the toilet were carried out that this was done with sensitivity and respect. We saw one person asked to be taken to the bathroom. A member of staff accompanied them immediately, chatting with them as they left the room. We saw staff enquired after people's welfare, asking if they felt better when they had been ill or if an ailment they were suffering from had improved.

Care plans we reviewed were seen to have been developed using a person-centred approach. For example in one care plan it was stated; "I would like you to place a green towel over my Zimmer frame to keep me covered and allowing me personal space when helping me with my personal cares." The manager and area manager told us that people who used the service and their relatives had been involved in developing and reviewing care plans. We saw that care plans were dated and signed by the manager and carers. However, we saw that signatures from relatives regarding the updates were not always completed. The area manager said they were trying to encourage more family involvement in care planning. They said it was something they wanted to promote through' residents and relatives' meetings.

We saw people's end of life wishes had been considered sensitively. The manager had sought active involvement and support from the families of people who used the service so that people's wishes could be identified and plans discussed.

The manager told us that no one who lived in the home currently had an advocate. They were however, aware of how to assist people to use this service. We saw information on advocacy services were on display in the home.

Requires improvement

# Is the service responsive?

## Our findings

At the last inspection we rated this domain as inadequate. We found that care plans lacked detailed guidance on the support needs of people who used the service and there was a lack of activity for people.

Records showed that people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the service. Following an initial assessment, care plans were developed detailing the care needs/support, actions and responsibilities, to ensure personalised care was provided. The manager and area manager said all care plans had been reviewed and re-written since our last inspection of the service to make sure they gave detailed guidance on people's support needs. The manager said they had improved the care plans but were still working towards continued further improvements such as more involvement of people who used the service or their relatives in the care planning and review process.

We saw that short term care plans had been developed for residents who were unwell/on antibiotics. One person's care plan said, "All staff to ensure that full course of antibiotics are completed and to monitor effectiveness. Care Staff to alert manager if coughing or breathless continues or increases." This showed the provider was responsive to the changing needs of people who used the service. We also saw that care plans showed evidence of input from external health professionals such as GP's and memory clinic professionals.

Staff spoke highly of the care plans and supporting documentation such as additional charts to record food and fluid intake. They said the new care plans gave them good guidance and were easy to understand. Comments included; "They are so much better now, tell you all you need to know" and "Very user friendly and informative." We saw care plans were being reviewed monthly and updated as indicated whenever the needs of people who used the service changed. Daily records showed people's needs were being appropriately met. Staff spoke confidently about the individual needs of people who used the service. It was clear they knew people and their needs well.

We looked at staff handover records and saw these showed the needs of people who used the service were discussed which meant that staff were kept up-to-date with the changing needs of people who lived at the home. However, we noted on one occasion it was recorded in the handover record that a person had complained of toothache and on another that a person had a sore area. This information had not been transferred in to the individual records of the people concerned which could lead to these needs being overlooked.

The manager and area manager told us the home currently had an activity co-ordinator who worked ten hours per week in the home. They said they had plans to increase this when the occupancy in the home was increased to 20 or 25 hours per week. The manager told us "We don't have a lot going on at the moment as our activities lead only attends two days a week but she will be doing 1:1 chats in the resident's rooms today." And "I have some budget aside to bring in some outside entertainers, singers as the residents like that, so it will get better soon."

We saw that the activities schedule was present on the notice board in the entrance area of the home. There was some activity scheduled to take place for each morning and afternoon. Activity on offer included; bingo, large dominoes, arts and crafts. One activity was listed as 'rest time'. We questioned with the manager and area manager whether this was an activity. We were told that this was the time when 1-1 chatting took place with people who preferred to stay in their rooms. They agreed the schedule needed to be worded to this effect. We also saw that outside entertainers were booked for twice in the coming month. Posters advertising this were on display in the home. There was music playing at various points throughout the home, including in people's rooms. We spoke with one person who used the service who was sat in the entrance hall listening to some 1960s music and tapping their feet. We asked if they liked the music and they replied, "Oh yes, it's the Drifters. I like that music."

We were told that one person who used the service had a particular interest in the garden and had a vegetable patch in the garden. After lunch on the first day of our inspection a member of staff went out with them and they spent time looking at the vegetables and flowers and discussing the visiting squirrels and cats. Another person was accompanied out on to the patio area after lunch to enable them to have a cigarette.

Some people who used the service told us they preferred to sit in the small lounge in the home. One person said they

# Is the service responsive?

enjoyed the peace and quiet of this room but enjoyed watching television programmes. During our visit we saw they were engaged in watching a programme and had the television controls to hand to change the channel if they wished.

On the first day of our visit we saw the activity co-ordinator led an afternoon activity. Fifties music was played in the background and memory prompt cards were distributed to people who used the service to enable discussion. The activity co-ordinator engaged with people in a friendly and pleasant manner and encouraged a lively historical discussion. On the second day of our visit a game of bingo took place. People who used the service told us they had enjoyed the game.

Several people mentioned feeling bored or that there was nothing to do at the home. One person said, “It can be a bit boring in the afternoons but the carers are lovely and I do enjoy a laugh with them.” When asked if there was anything they would change at the home, one person said “It's very boring. There's nothing to do. That's what I'd change. I would like more sport. They never ask you what you'd like to do. I'd like more football and cricket. After a while it gets boring.”

We looked at the minutes of ‘residents and relatives’ meetings and could see ideas and suggestions on how activity in the home could be improved had been discussed. Staff told us that they had time to engage in activities with people who used the service during the afternoons and late mornings. We saw on one of the days of our visits that the care staff organised a game of large dominoes. We also observed the care staff spending time with people who used the service on a 1-1 basis, for example, reading a newspaper or chatting.

The home had systems in place to deal with concerns, complaints and compliments, which included providing people with information about the complaints process and a complaints policy. We saw that one compliment had been received by the home between April 2015 and July 2015. The example from a visitor was ‘Very pleased exceptionally, do everything for [Name of person], especially food. All the girls are great, [Named three carers], [Name of person] pleased with all staff, highest compliments.’

We looked at the ‘monthly compliments and complaints monitor’, which detailed the date, nature and status of complainant, overview of complaint, action taken, outcomes reached and date resolved/name/signature of the home manager and the area manager. Between April 2015 and July 2015 we saw two complaints recorded which had been satisfactorily handled in a timely way. The action noted was ‘staff spoken to at handover’. Staff confirmed they were given information on the outcome of complaints. This meant that complaints were dealt with to minimise the risk of the same issue arising in the future. We saw from staff meeting minutes that any feedback on concerns and complaints was discussed with staff in order to prevent re-occurrence of issues.

The area manager told us that the service reviewed complaints annually to detect themes or trends, and confirmed that no themes had been identified. Compliments and complaints were used as a learning tool to ensure improvements in the service and to provide additional information regarding the standard of the service.

Requires improvement

# Is the service well-led?

## Our findings

At the last inspection we rated this domain as inadequate. We found at that time that the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others and that safeguarding notifications had not been sent as required to CQC.

At the time of this inspection there was no registered manager. A manager had recently been appointed and was in post to manage the service. They said they would be commencing the process for registration with CQC shortly. The manager, supported by a team of senior care staff and care staff supervised the care given and provided support and guidance where needed. The area manager was also new to this home and provided support to the manager in their role. The manager said they received good support from the area manager and owner of the home. Staff said the area manager visited the home at least weekly but often more.

Staff said they felt well supported in their role. They said the management team worked alongside them to ensure good standards were maintained and the manager was aware of issues that affected the service. Staff said the manager was approachable and always had time for them. They said they felt listened to and could contribute ideas or raise concerns if they had any. They said they were encouraged to put forward their opinions and felt they were valued team members.

We saw staff meetings were held on a regular basis. We looked at the minutes of staff meetings and concluded that effective mechanisms were in place to give staff the opportunity to contribute to the running of the home. In addition, care issues were discussed which meant that any key risks were communicated to staff about people who used the service, thus care provision was enhanced.

All the staff we spoke with said the current manager and area manager had made a difference to the home with the positive improvements they had introduced. Their comments included; “It’s a much better atmosphere now, we work well as a team”, “It’s so much better organised, a great place to work” and “The new manager is very committed and there for the residents.”

The manager was visible in the home and chatted with people who used the service who appeared to feel comfortable with her. Several people, including both visitors we spoke with said that they thought that the manager had had a positive impact on the home. One visitor told us that they felt that the new manager was improving things, and that they felt their relative was safe and well cared for.

We saw at this visit that the provider had a quality assurance programme which included monthly visits by the area manager to check the quality of the service. We saw detailed reports of the visits and action plans and timescales for any areas for improvements; the plans were for the provider quality assurance report to be undertaken every three months at a minimum. Areas identified for improvement included; décor, furnishings and staff supervisions.

Other quality assurance systems were in place in the home to assess and monitor the quality of service that people received, together with systems to identify where action should be taken. The area manager showed us the quality assurance matrix that detailed the range of audits undertaken. We saw these included; monthly care plan audits, monthly medicines audits, three monthly infection control and prevention audits and monthly weight audits. At this inspection we saw the audits were effective and showed evidence of the follow up action taken by staff to improve the service.

People who used the service and their relatives were asked for their views about the care and support the service offered. The area manager showed us the results from the survey undertaken in July 2015, which explored the following areas: general appearance of home, catering, domestic and laundry services, activities and accessibility to outside services. The overall satisfaction with the service was high. The laundry service had been rated as poor by some people and the area manager told us of their plans to ensure improvements in this area.

We looked at the records of safety checks carried out in the home. These included maintenance records, fire records and water safety check records. There was evidence these were carried out regularly and any actions identified were clearly documented to show they had been addressed to improve the service. There were systems in place to monitor accidents or incidents and we saw that the service learnt from incidents, to protect people from harm which indicated there was a commitment to continuously improving practice in the home.

Requires improvement

# Is the service well-led?

The manager or area manager had informed CQC about events that had occurred in the home since our last inspection. These included safeguarding matters and accidents. We saw a log was kept of these and the records were easily accessible.

The provider had a number of policies and procedures in place to govern activity and we saw these were available to staff on the computer within the home. The area manager told us that the policies and procedures were currently being reviewed/ updated by the operational manager and provider as many had not been reviewed since 2012. This meant that staff were not working to up-to-date protocols and there was a risk that a consistent level of care and support may not be provided. The area manager was aware of the need to get the policies updated to ensure they reflected current practice.