Riseley Beds Limited

Brook House Residential 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 23 June 2016. It was unannounced.

Brook House Residential Home provides a service for up to 20 older people who may also be living with dementia. The registered manager reported this to be more than 75% of the 19 people living in the home on the day of the inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found that improvements were needed to ensure people were safe. This included the processes to check staff were suitable to work at the home, and the way in which identified risks to people were being managed.

There were sufficient numbers of suitable staff planned. However, due to staff sickness, there were times when staffing levels were insufficient to meet the needs of people on the day of the inspection. We also found that further work was required to ensure all staff working at the service had the right skills and training to meet people's needs.

The service worked to the Mental Capacity Act 2005 key principles however, improvements were needed to gain people's consent to the care and support provided to them. In addition, we found that people's privacy and dignity was not always adequately respected and promoted.

People were supported to have sufficient to eat and drink, but some improvements were needed to ensure their individual food and drink preferences were taken into account and followed.

People received personalised care that was responsive to their needs. However, some care records needed reviewing; to ensure the care recorded met each person's current needs and also reflected their involvement in the assessment and planning of their care.

The arrangements in place to monitor the quality of service, in order to drive continuous improvement, were not adequate.

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

Systems were in place to ensure people's medicines were managed in a safe way and that they got their medication when they needed it. They were also supported to maintain good health and have access to

relevant healthcare services.

Staff were motivated and provided care and support in a caring and meaningful way. People were also given opportunities to participate in meaningful activities.

There was a registered manager in post who provided effective leadership at the service, and promoted a positive culture that was open and transparent. Systems were in place to enable people to raise concerns or make a complaint, if they needed to.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements were needed to ensure robust checks were in place for all staff, before they worked at the service.

Individual risks to people had been identified. However, further work was required to ensure the control measures to minimise risks were adequate.

There were times when staffing levels were insufficient to meet the needs of people on the day of the inspection.

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

Systems were in place to ensure people's medicines were managed in a safe way and that they got their medication when they needed it.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed to ensure people's consent is obtained before care and support is provided.

Improvements were needed to ensure everyone working at the home had the right training to meet people's needs and keep them safe.

People were supported to have sufficient to eat and drink.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always adequately respected and promoted.

Staff were motivated and treated people with kindness and compassion.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were needed to ensure people were involved in the assessment and planning of their care.

Systems were in place to enable people to raise concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The arrangements in place to monitor the quality of service were not adequate.

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

The service promoted a positive culture that was open and transparent.

Brook House Residential 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 was unannounced and took place on 23 June 2016. 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also 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 10 people living in the home, and observed the care being provided to a number of other people during key points of the day, including lunch time and when medication was being administered. We also spoke with the registered manager, the deputy manager, two care staff and the cook.

We then looked at care records for four 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

The registered manager described the processes in place to ensure that safe recruitment practices were being followed; to confirm 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 although the majority of required checks had been carried out, some had not. For example, one person employed since 2013 did not have a DBS check in place, which the registered manager admitted was an oversight on her part. The member of staff was not providing direct care to people but had come into close proximity with them on a regular basis. This meant there was potential for people to have been placed at risk, if the member of staff was not suitable to work at the home.

We saw that the registered manager used a checklist system to record which pre recruitment checks had been completed for new staff members, but these did not incorporate all the legally required checks. The checklists had not always been completed fully either; meaning the systems in place to ensure new staff were suitable to work in the home, were not adequate.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was able to show us during the inspection that she had taken immediate action to arrange a DBS check for the staff member without a check in place, and confirmed later that this had been received. She also told us she had obtained a new recruitment checklist, which would support her in ensuring all staff working in the home had the correct legal checks in place, before they started working at the home. During the inspection, we also saw that references were taken up for the young volunteers that came into help out with activities, and the registered manager confirmed that they were always supervised and never took anyone out from the home without supervision.

People felt that the risks associated with their care and support were being managed appropriately. One person told us: "I have a cushion for my back for support, I don't have any sores." Staff spoke to us about how risks to people were assessed; to ensure their safety and protect them. They described the processes used to manage identifiable risks to individuals such as malnutrition, moving and handling, skin integrity and falls. One member of staff told us that risk assessments were added to people's care plans and information was given to them in handover. Another staff member said: "We have very few falls."

We saw that people had individual risk assessments in place to assess the level of risk. These had been reviewed on a regular basis; to ensure the care being provided was still appropriate for each person. We saw that specialist equipment had been provided for people at risk of developing a pressure ulcer. We observed a staff member bringing a pressure relieving cushion out to someone who had chosen to sit outside. It was evident from the conversation between the staff member and the person that staff frequently reminded the person to use the cushion. We also saw people being supported to walk with mobility aids or linking arms

with staff; with the aim of keeping them safe and secure and to minimise the potential for falls to occur. On the whole staff took their time and talked to people throughout, providing them with reassurance and an understanding of what was happening. However, there were occasions when we observed people almost being pulled along, because the staff member's pace of walking was much quicker than theirs, which placed them at possible risk of harm if they were to trip for example.

We noted that some of the control measures put in place to minimise the level of risk identified, were not always adequate. For example, a risk assessment for someone at risk of falling recorded that the person needed to use a walking aid and have a sensor mat in place, to reduce the risk of them falling. However, we also read that the person did not always remember to use their walking aid, or would sometimes walk around the sensor mat, making the control measures less effective. Although there was no evidence that the person had experienced any harm as a result, the registered manager told us she would review the risk assessment to ensure the risk was managed in the most appropriate way for the person.

Records showed that incidents, accidents and falls were analysed; in order to identify any patterns and minimise the likelihood of a reoccurrence. Other records showed that systems were in place to ensure the premises and equipment was managed in a way that ensured the safety of people, staff and visitors. The registered manager confirmed there was no formal written business continuity plan for the service; to support staff in the event of an emergency happening and needing to move people out of the building for a while. However, she talked about the home being part of a wider village contingency plan, following recent winter floods, where people in the local community had come together to support those at need – including someone living in the home who had needed to get through the flood water to get to hospital.

There were times during the inspection when staffing levels did not meet people's needs and keep them safe. People felt that the staff did their best and that overall they responded in a timely way when they called for help. One person told us: "I don't wait too long as a rule; if they are busy it can be a bit longer. They do their best." Another person added: "Well, on the whole they are pretty good, sometimes we have to wait a little while – I know I am impatient."

Staff talked to us about staffing levels in the home. They told us that enough staff were planned for each shift but that planned staff did not always come into work. On the day of the inspection this had happened leaving the morning shift with three care staff instead of four, to meet the care and support needs of 19 people. We did note that the deputy manager and registered manager were supernumerary, and they were able to provide additional support when needed. In general we saw that people had their needs met in a timely way, but there were times when they had to wait for assistance. For example, before lunch we observed a service user get up to walk without their walking frame, which had been stored outside the dining room. On another occasion we saw someone trying to negotiate some stairs between the ground floor toilet and the dining room. The person was walking with the aid of a frame and was clearly not able to negotiate the stairs on their own. On both occasions staff were quick to respond however, there had been potential for them to have come to harm.

We spoke with the registered manager about staffing levels on the day and she told us that this had been an unusual day. We did note from speaking with staff, and our own observations, that staff were particularly busy. This was due to a death the night before, staff sickness, dealing with someone who needed to see a GP and was later admitted to hospital and managing the needs of a person who had recently started to come to the home for day care. The registered manager told us that with sufficient notice she was able to get cover for absence from within the staff team, but on this occasion she had not been given enough notice. She commented on how well the staff pulled together to support the needs of the service, and rotas we looked at supported this. The registered manager told us there was a low turnover of staff but she was

looking to recruit an additional member of staff to provide more flexibility in covering absence and holidays. We read some recent written feedback from a relative which supported the registered manager's comments. They had written: 'A higher than average ratio of staff to patient/residents meant that there were always at least 4 or 5 people on duty. Plenty of young care workers as well as older more mature - so a good mix'.

People echoed this feedback when they talked to us about how safe they felt safe living in the home. The reasons they gave varied but in essence they told us they felt safe because someone was always around. One person said: "Oh yes I do feel safe, they do keep an eye on you as much as they can." Another person told us: "It's the company dear. Everybody is nice to talk to, we all get on well – no one upsets anyone. That's why I feel safe." A third person added: "They are very good to us here – very kind. That helps me feel safe." We also read some more feedback from a relative of someone living in the home who had written: 'I feel that my mother is well looked after, safe and happy at Brook House'. We observed that people were relaxed in the presence of staff and often looked to them for support and reassurance.

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 staff member said: "Yes I do feel residents are safe. We do whatever we can for the residents." Another staff member told us if they witnessed a member of staff speaking to someone in an inappropriate way, they would report it straight away to a senior member of staff. We saw that information was on display which contained clear information about whistleblowing procedures and safeguarding, including who to contact in the event of suspected abuse. Records we looked at confirmed that staff had received training in safeguarding and that the home followed locally agreed safeguarding protocols.

Systems were in place to ensure people's daily medicines were managed so that they received them safely. A relative had recently provided the following written feedback about the service: 'Administration of medications and access to local doctor's surgery, if required, are excellent'. We observed a member of staff administering medication to people at lunch time. We noted they did not rush people and gently took the time to explain what medication they were giving them and how best to take it.

Staff confirmed they had received training to be able to administer medication. They demonstrated a good awareness of safe processes in terms of medication storage, administration and about the purpose of the medication prescribed for people. Records were being maintained to record when medication was administered to people, and individual medication profiles provided clear information for staff in terms of the purpose of each medication prescribed for people. We also saw that medication was stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medication.

Requires Improvement

Is the service effective?

Our findings

People provided mixed feedback about whether staff sought their consent and involved them in decisions about their care. One person told us: "They tell me what they are going to do, oh yes they do." However, other people were less sure. One person said: "I wouldn't say they do ask really, they just tell me what is going on." Another person added: "I think they generally tell me what they are going to do." We talked to staff about how they gained consent from people and they were able to give us examples of good practice. One staff member told us: "I ask them if they are comfortable if I stay in the room when they use the commode." Another staff member said: "I would explain what I am doing and why, encourage them to help themselves and help if needed."

We observed inconsistencies in the way that staff sought consent from people before providing care and support. For example: a staff member moved one person from one chair to another by taking their hand; to make room for another person who had come into the room. At no point did the staff member speak to the person they were moving or seek their consent. We observed that when the staff member had left the room the person who had been moved stood up and moved position again, indicating that they had not wanted to sit in the chair they had been moved to. When people were taken into lunch the same approach was seen with people being led through to the dining room by their hands. A staff member was heard telling people: "Come on its lunch time I am taking you through to lunch." Although there was no indication that people were not happy to go with them, staff didn't take the time to check with people if were ready for lunch first. Similarly, at lunchtime, people were served by staff in a friendly manner, but they didn't stop to explain to people what they were being given to eat, or ask if they needed help. One person we spoke with was unclear about what they had been given to eat, and another person was heard asking for help to cut up their food, after staff had walked away. We observed that a staff member did come back to assist shortly after the person called out for help.

We also found a Do Not Attempt Cardiopulmonary Resuscitation form in place for one person that had been signed by a doctor. There was no evidence that this had been discussed with the person or their family, so we could not clear if the person was aware of, or understood the reason for, the decision being made.

The home had three double, shared bedrooms which were all in use on the day of the inspection. The registered manager confirmed there was no written evidence to support the fact that people had consented to sharing these rooms. Verbal feedback we received from people indicated that the majority of people did not want to share. One person told us: "I really would prefer to be on my own if I had a choice. It's all about time on your own." The registered manager explained that the decision for people to share was often influenced by finances, and lay with people's relatives. She told us about a recent incident where one person sharing a room had needed to be removed at night time by staff who had been concerned about their safety, due to the behaviour of the other occupant. This had resulted in the person being taken to the lounge to nap in a chair. Records also highlighted a negative incident between two different people who had been sharing a room, which had resulted in them having to move rooms. Although it was positive that the home had taken action quickly in each case to keep people safe, it did not demonstrate that the decision for people to share bedrooms was in their best interests, or that compatibility had been considered

beforehand.

These were breaches of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager acknowledged our concerns and told us she would take steps to obtain people's consent to sharing rooms before they moved in in future. She spoke about reducing the number of shared rooms from three to two as soon as a single room became available. She also told us that she would discuss the importance of obtaining consent from people with staff on a group and individual basis.

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 systems were in place to assess peoples' capacity and appropriate DoLS applications had been submitted to the local authority for authorisation, with clear information available for when applications to extend existing authorisations were due. Staff told us that DoLS were primarily the responsibility of the management team, although they had some awareness of these. One staff member told us: "Yes I have touched on that, of course the manager is always talking about that."

People received effective care from staff with the right skills and knowledge. One person told us: "Yes there are no problems; they are all able to care for me." Another person added: "A lot of the staff have been here a long time." Staff told us they received training which gave them the skills and knowledge they needed to support people. They told us that most of their training was computer based learning. One staff member talked about induction training and told us: "Management are responsible for that but, I have done it sometimes like showing them [new staff] where the fire exits are and where to find policies and procedures."

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 safeguarding, dementia awareness, moving and positioning people, pressure ulcers, malnutrition, urinary catheterisation, medication, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw from this that training had been provided to meet the specific needs of people living in the home, and that training was arranged in response to incidents that had happened in the home. We did find that some non care staff had not received relevant training in areas such as safeguarding and dementia. This would have provided them with important knowledge and an understanding of the needs of people they came into close contact with on a regular basis. The registered manager undertook to address this after the inspection. However, from speaking with staff and observations throughout the inspection, we found staff had the right knowledge and skills to meet people's needs. For example, we observed staff using their training effectively in terms of minimising the risk to people of developing a pressure ulcer.

Staff told us that staff meetings were being held to enable the registered manager to meet with them as a

group, and to discuss good practice and potential areas for staff development. One staff member told us: "Yes we do, I know that they are bringing in more because we have requested them." Records showed that the last staff meeting had taken place in February 2016 and the registered manager confirmed the next meeting was planned for 18 July 2016. Staff also confirmed that they had received recent supervision, which provided them with additional support in carrying out their roles and responsibilities. Records supported this and showed that all staff had received supervision in April or May 2016.

People provided a mixed response regarding the food provided to them. They told us they had enough to eat and drink and most people enjoyed their meals. One person said: "The food is good. We get a variety from day to day; they do use lots of fresh vegetables." Another person told us: "I enjoy the food yes, it is very good." Relatives echoed these comments through recent written feedback. One relative had written: 'The meals look wonderfully appetizing, very individually prepared and offered in a calm, unrushed manner. Appropriate support always given, in a respectful manner (no standing, chatting over residents) engagement is observed'. Another relative had written: 'The food is excellent and my mother now eats heartily whereas previously she was not interested in food'.

A notice board in a communal area of the home indicated there was a choice of food each day, but people were less clear about this. One person told us: "No we don't really get a choice – one main meal a day, but each day is different." Another person said: "Well we do get given a choice but it doesn't always appear in the dining room." The cook told us that people were asked on the day what they would like to eat, and on this day everyone had chosen the same. At lunch, we saw that everyone in the dining room was served crumble and custard for dessert. One person told us: "I don't like custard but still they give me it." We heard the person repeat this to two members of staff, but the dessert was not changed. We did hear the cook later giving people a choice of sandwich filling for their tea.

At lunch time we noted that dining tables were laid appropriately; providing a visual clue for people living with dementia that it was time to eat. The meals we saw looked and smelt appetising and people were given adequate time to eat and drink. Assistance was provided in a discreet manner to those who required help with eating and drinking. For example, some people were given deeper plates; to enable them to eat independently. People were also able to eat in their rooms if they wished to.

The cook had a good awareness and understanding of people's individual nutritional needs and how to meet these, for example, one person had a milk intolerance and other people required fortified diets, because they were at risk of malnutrition. We saw that people's nutritional needs had been assessed and food and fluid charts were used to record people's intake where concerns had been identified. Throughout the day, food and drinks were provided on a regular basis.

We saw that people's weight had been regularly monitored, to support staff in recognising potential health problems associated with weight loss or gain. We also noted that referrals were being made to the local dietetic service as required.

People confirmed they were supported to maintain good health and have access to relevant healthcare services. One person told us: "I am sure they would get the GP if needed, they did yesterday for someone." Another person said: "Yes they would get somebody for you and look into it." A relative had also provided the following written feedback recently: 'Good personal care shown by the homes staff in relation to on going medical issues experienced by my elderly mother. Concern shown to ensure best possible outcomes for her in the light of her individual situation and in liaising with local healthcare institutions and professionals'.

Staff told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support. A GP was called out on the day of the inspection to assess someone with changing needs. Records demonstrated that referrals were made to relevant health services when people's needs changed for example, the local falls service or memory clinic, and that staff were quick to respond when someone's needs changed. A record of visits to and from external health care professionals was being maintained for each person, and records we saw showed that people were in regular contact with external healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Overall, people told us their privacy and dignity was respected. One person told us: "They do treat me with respect and dignity. I have not witnessed anyone being unkind to a resident." A relative had also provided the following written feedback: 'My mother has been a resident for over a year now. She has always been treated with the utmost care and dignity. All the staff are lovely with her and I am particularly delighted with the attitude of the young staff. They are a credit to the management and society'. Staff talked to us about how they respected people's privacy and dignity. They were able to provide examples of good practice. For example, one staff member said: "I usually draw curtains and shut the door. I would use the room divider in a shared room." A male member of staff told us that people were able to choose who provided them with personal care. They said: "Most of the ladies don't want a man helping them with their personal care."

However, we overheard a conversation between a member of staff who was discussing the rapidly changing healthcare needs of a person living in the home, with their GP. The staff member was clearly anxious to understand the outcome of the visiting GP's assessment, but they failed to maintain the person's confidentiality because the conversation was held in earshot of us and 13 people - including the person in question. Of further concern was the fact that the content of the conversation could have caused alarm to the person being spoken about.

We spoke to people who were sharing bedrooms and asked how their privacy and dignity was maintained. They provided a mixed response. One person told us: "I am happy sharing my room, no problem at all. For privacy we do have a curtain." However, another person said: "I want to be on my own, there isn't one free at the moment, a single room I mean." They added: "There was a bit of an upset you see, but usually I think they do try to pair you up with someone similar." The registered manager was very open with us and explained about the 'upset'. She told us about an incident that had happened the previous night, which had involved a person from a shared room needing to swap beds with someone in a single room. The incident raised questions about how people's dignity could be adequately upheld when sharing a bedroom.

We looked at all three shared bedrooms and noted two were small and did not provide people with adequate useable space of their own. In one room the beds were so close together that the occupants would have been able to touch each other. In addition, none of the shared rooms afforded people an adequate level of privacy, for example, if they needed to use the commode. Curtains had been placed in each room in an attempt to provide each occupant with some privacy, but we noted that they only pulled part way across the rooms. This meant that one occupant would need to cross through the other occupant's space to enter or exit the room. The registered manager acknowledged our concerns and agreed to convert the smallest of the shared bedrooms into a single room as soon as a single room became available. She added that in the interim, steps would be taken to afford people better levels of privacy and told us she was costing up more substantial privacy screens for the remaining shared bedrooms.

People confirmed that they were treated with kindness and compassion. They spoke positively about the care and support they received. One person told us: "They are all very kind; they are so kind and good to me here." Another person said about the staff: "There is such a very happy atmosphere, a good bunch of

people."

Relatives echoed these comments through written feedback. One relative had written: 'From the first day my mother was admitted to Brook House to this date we as a family have been more than happy with the care that has been afforded to her'. Another relative had written: 'As soon as you walk through the door you know that this is a home which really cares for the residents'. A third relative commented on the staff team's approach to supporting people living with dementia. They had written: 'He had dementia and yet was able to get much enjoyment out of the last few months of his life, thanks to the love and fun he was shown'.

We observed during the inspection that staff provided care in a person centred way and there was an easy familiarity between people and staff. We heard lots of light hearted, but respectful, banter being exchanged between people and staff. Staff demonstrated their caring approach. For example, one person was particularly demanding of staff time and attention. Despite having to oversee and manage a busy day in the home, and our inspection, the registered manager was heard repeatedly providing reassurance to the person in a meaningful and gentle way. When someone needed to go to hospital, the registered manager quickly made arrangements with the family for a member of staff to accompany them, until the family could get to the hospital. This meant that the person was not alone and was accompanied by someone familiar with their needs. In addition, after lunch the cook came to have a hot drink with someone who was sitting outside in the home's courtyard. We noted a warm and meaningful approach from the cook as she chatted away with the person. It was evident from the person's replies and body language that they felt relaxed in her company.

People were involved in making day to day decisions about their care and routines. We noted that staff listened to them and provided information in a way that was appropriate for each person. We saw that people's decisions were respected. For example, people had complete freedom of movement around the home and the courtyard. We observed people moving about as they pleased and noted there to be a calm and relaxed atmosphere as a result.

People told us there were no restrictions on visiting times for residents. A relative had provided written feedback as follows: 'As a visitor we are always welcomed'. We heard conversations between staff and people that clearly demonstrated that people were encouraged to maintain relationships with friends and family. People told us they were encouraged to go out and about with friends and family if they were able to and some people shared their plans for the coming weekend.

Requires Improvement

Is the service responsive?

Our findings

Staff talked to us about how people received care that was responsive to their needs. They told us that before people used the service, they were asked for information about their needs. This information was then used to develop a care plan that reflected how each person wanted to receive their care and support. We reviewed care records and found that people had been asked for information prior to moving in. However, we noted in one person's file that the assessment form used by the service had not been fully completed in key areas such as the reason for admission, skin assessment, past medical history and eating and drinking, including preferences. We noted from other records that the person was at risk of developing pressure ulcers and malnutrition. Additional more detailed information had been provided by the person's GP as part of the assessment process. Although there was no indication that the person's needs were not being met, this did not demonstrate how the management team had assured themselves that they had asked the right questions or had sufficient knowledge to determine whether they could provide the right care and support, before the person moved in.

We saw from records that people and their families, where appropriate, had been involved in reviews of their care. For example, a relative had provided the following recent written feedback: 'My sister attended the review with my mother. The report was thorough and useful. One or two inaccuracies were quickly corrected'. However, care plans did not demonstrate people's involvement in the initial planning of their care. The registered manager acknowledged this and told us this would be addressed, and she would make sure everyone's care plans were properly reviewed to ensure they reflected their current needs, with their involvement as far as possible.

Staff talked to us about people's care plans and told us they were reviewed regularly. They also said that if there was a change in a person's needs, their care plan would be reviewed and staff would be updated. Care plans we looked at provided basic information for staff to enable them to meet people's care and support needs. They had been evaluated regularly; to ensure the care and support being provided to people was still appropriate for them. Some of the plans lacked sufficient detail to ensure care and support was provided in a consistent and personalised way. For example, one person's plan stated: 'I like to wash the bits I can', but the plan did not include further detail for staff to know which bits the person could wash themselves and which bits they needed help with.

There was also some confusion and overlap in terms of the paperwork in place. For instance, we found that one person did not have a care plan to instruct staff on how to manage their needs in terms of social needs, falls, personal care, moving and handling or skin integrity. We noted that the person had risk assessments in place for each of these areas, which listed the control measures for staff to follow; to reduce the likelihood of risks. However, these did not provide sufficient information to ensure the person's needs were met in a personalised way that was reflective of their individual preferences. Despite this, there was no evidence that people's individual preferences were not taken into account, and it was clear from speaking with staff that they knew people's needs well. The majority of staff had worked at the home for some time, and they were observed providing care in a personalised and meaningful way. The registered manager explained that the current care plans had limited space to write in, but acknowledged our concerns and told us after the

inspection that she had begun making enquiries about a new electronic care planning system to address this.

People talked to us about their hobbies and social interests. One person told us: "We don't really have activities; we sometimes have a sing song. We do have the youngsters come in during the evening." The registered manager explained that they had seven young volunteers who came in from the local community to help out with non personal care related tasks and activities in the evenings and weekends. Another person said: "No we don't get to go out unless our friends or family take us. I would like to go out more. I thought we were going to do exercises to music [today] but it was a chat and then a sing along." A third person added: "They do their best really, but we do get bored unless we have our own books to read or the paper, and you have to pay for your own paper so no one does."

Relatives provided a mixed view on the activities provided through written feedback which had been recorded recently. One relative had written: 'There is a lot for her to do if she feels like it. There is a day centre next door and they have their own minibus so they have trips out'. However, another relative had written: 'Entertainment and activities can be rather limited (except for the day centre) the garden is nice but, apart from the yard, is not available for use by residents. There used to be some light hearted evening entertainment (bowling, bingo, games) but these seem to have stopped now'.

We noted that there was a programme of activities on display in a communal area of the home. We also saw a big display of photographs to commemorate the Queen's 90th birthday and heard someone living in the home chatting to a member of staff about an external entertainer who had come in, and a special of lunch of salmon accompanied by fizzy wine that had been laid on to celebrate. During the inspection, activities were attempted with people including a discussion about weddings. Although this was appropriate for some people, we noted that a number of people did not, or were not able to, engage in this activity. Later a parcel arrived for the registered manager which contained craft items, including painting activities.

The registered manager told us that the day centre, which was in the grounds of the home, was open on Mondays and Wednesdays. She told us some people from the home used the day centre for activities, alongside a few members of the community. We were told that a hairdresser came every Monday and this was confirmed by one person living in the home, who told us they were very good. We also saw that the home kept chickens and had two cats, which provided some entertainment and company for the people living in the home.

Everyone we spoke with told us they knew how to make a complaint or raise a concern. People told us they would either speak with a member of staff or tell their relatives. No one said that they would feel uncomfortable raising a complaint if they needed to do so.

We saw that information had been developed for people outlining the process they should follow if they had any concerns. The registered manager showed us that a record of complaints and compliments was being maintained. We noted from this that concerns were taken seriously, and updated to record any actions taken in response. This showed that people were listened to and lessons learnt from their experiences, concerns and complaints. We were also able to read some recent written compliments from relatives too. They had written: 'We will never forget the loving care each one of you gave mum', and 'Thanks for the excellent service caring for mum and all the other residents, and going the extra mile looking after us too when we visit'.

Requires Improvement

Is the service well-led?

Our findings

The arrangements in place to monitor the quality of service were not adequate. The registered manager talked to us about the monitoring systems in place to check the quality of service provided to people. She told us about a small number of individual internal audits covering areas such as medication and care plans. However, she confirmed that she did not currently have wider systems in place to enable her to have an overall picture of the service provided, from a managerial perspective. There was no evidence for example, of quality monitoring checks being carried out in key areas such as staff recruitment or risk management. We found improvements were required in both these areas. This meant the systems and processes to identify and assess risks to the health, safety and welfare of people using the service were insufficient.

In addition, we identified during this inspection that improvements were required in how the service sought people's consent to the care and support provided. There was limited evidence that decisions in relation to people's care and support had been discussed with them, or an accurate record of those decisions maintained. Our findings have therefore raised questions about the effectiveness of the small number of audits that were being carried out internally. The inspection has also highlighted a deficit in terms of other areas that had yet to be appropriately checked. This did not demonstrate that the service's approach to quality was integral and that effective governance systems were used to drive continuous improvement.

This was a breach of Regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us there were opportunities for people and relatives to be involved in developing the service, which included completing satisfaction surveys. She told us that surveys had been sent out recently to relatives but not returned. However, she was able to direct us to recent feedback that 16 relatives had provided online about the service from March 2015 to June 2016. The results of the reviews showed that the 16 relatives had given the service an average score of 9.5, with 10 being the maximum score.

We saw useful information around the home for people, staff and visitors about safeguarding arrangements, meal times, staff working in the home and the Care Quality Commission (CQC). Clear information had also been developed for prospective users of the service, setting out what they could expect from the service. This demonstrated an open and transparent approach in terms of how information was provided to and communicated with people. The registered manager told us she was planning to introduce quarterly newsletters to update relatives and the local community on the services provided at the home. It was evident that the home had strong links with the local community from speaking with the registered manager and looking at records. For example, through the home's daycentre and the young volunteers that came in on a daily basis.

The service demonstrated good management and leadership. People knew who the registered manager was and staff told us they felt well supported. One staff member told us: "I feel supported. The manager has an open door policy." During the inspection we saw that the registered manager spoke with people to find out how they were and was involved in their support and wellbeing. The registered manager knew people's

names and interacted with them on a personal level, making them feel at ease and sharing a laugh and a joke.

Staff made positive comments about the open culture at the service. We observed staff working cohesively together throughout the inspection and noted the way they communicated with one another to be respectful and friendly. Staff appeared relaxed speaking with us and we also found the management team to be open and knowledgeable about the service - they responded positively to our findings and feedback.

Staff we spoke with were clear about their roles and responsibilities across the service. They were able to describe the visions and values of the service as: "Give the best quality care that we can" and "Always give my best." Staff told us they enjoyed working at the home and they demonstrated great respect for one another and the service overall.

Systems were in place to ensure legally notifiable incidents were reported to us, the CQC in a timely way. Our records showed that this was happening as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The arrangements for obtaining consent from people, prior to providing care and support, were inadequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The arrangements in place to monitor the quality of service, in order to drive continuous improvement, were not adequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures to ensure staff working in the home had legally required checks in place before they were employed, were not adequate.